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DEPARTMENTS OF LABOR AND HEALTH, EDUCATION, AND WELFARE APPROPRIATIONS FOR 1968

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HEARINGS

BEFORE A

SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS HOUSE OF REPRESENTATIVES

NINETIETH CONGRESS

FIRST SESSION

SUBCOMMITTEE ON DEPARTMENTS OF LABOR AND HEALTH, EDUCATION, AND WELFARE AND RELATED AGENCIES

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ROBERT M. MOYER, *Staff Assistant to the Subcommittee*

PART 2

STATEMENT OF THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE

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STATEMENT OF THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE



Printed for the use of the Committee on Appropriations

U.S. GOVERNMENT PRINTING OFFICE
77-453 WASHINGTON : 1967

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MONDAY, MARCH 13, 1967.

OVERVIEW OF BUDGET ESTIMATE FOR THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

WITNESSES

JAMES F. KELLY, ASSISTANT SECRETARY, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
JAMES B. CARDWELL, DEPUTY ASSISTANT SECRETARY FOR BUDGET

BIOGRAPHICAL SKETCH OF PRINCIPAL WITNESS

Name: James Francis Kelly.
Position: Assistant Secretary, Comptroller.
Birthplace and date: Washington, D.C., August 5, 1915.
Education: Studied at Columbus University, both the Law School and the School of Accounting. Received LL.B 1940. Admitted to D.C. Bar 1940
Experience:
1966 to date: Assistant Secretary, Comptroller, HEW
1961 to 1965: Deputy Assistant Secretary for Administration and Comptroller, HEW
1954 to 1961: Director, Office of Financial Management, Deputy Comptroller, and Budget Officer, HEW
1948 to 1954: Director, Budget Branch, and Assistant Director, Budget Branch, Public Housing Administration
1946 to 1948: Regional Budget Officer and Statistics Officer, Public Housing Administration, New York, N.Y.
1943 to 1945: Ensign to Lieutenant, USN
1942 to 1943: Principal Budget Analyst and Administrative Analyst (production), Federal Public Housing
1941 to 1942: Administrative Assistant and Director of Production Control, U.S. Housing Authority
1939 to 1941: Assistant Office Engineer, U.S. Housing Authority
1934 to 1939: Clerical and statistical positions ranging from Under Clerk to Sr. Statistical Clerk with the U.S. Housing Authority and its precessor agency, the Housing Division of the Public Works Administration, while attending school
Outside associations:
Federal Government Accountants Association
American Society for Public Administration
Lectured on "Comptrollership" for George Washington University at the Industrial College of the Armed Forces
Frequent lecturer in public administration. These include seminars and training programs for HEW, the U.S. Civil Service Commission, Brookings Institution, and colleges and universities.

Mr. FLOOD. James F. Kelly, the Assistant Secretary, will give us the highlights and a general overview of the budget before we hear from the Secretary and then the constituent agency heads, bureau chiefs, and so forth, on the details.

GENERAL STATEMENT

Mr. KELLY. I thought it would be helpful to the committee if before you took up the first item we identified for you in a relatively

simplified form what the major components of the Department's budget were and placed them in some kind of context.

Mr. FLOOD. This will be very helpful for the new men on the committee, very.

Mr. KELLY. As you know, the Department spends both general funds that come from regular taxes and trust funds that are derived from social security taxes. From the general fund, the new obligational authority in 1967 will be $12.3 billion, assuming the enactment of proposed supplemental appropriations. Today the President sent to you a request for supplemental appropriations. They are to cover all of the program items. There are still to come, as I understand it, some requests associated with pay increases.

1967 SUPPLEMENTAL ESTIMATES

Included in the figures on these charts are the proposed supplementals. They add up to about $623 million and they include a small amount, about $8 million, which relates to pay increases. The balance covers the following items, if I might read them to you: The Teacher Corps is an item of $12,500,000. We continue that operation in the fiscal year 1967.

Mr. FLOOD. This is in the supplemental.

Mr. KELLY. Yes.

Another item is educational improvement for the handicapped. This was a law enacted in the closing days of Congress. We are asking for $2.5 million in order to do the initial work so that we can carry out the program in 1968.

In the area of vocational rehabilitation we are proposing a supplemental of $15 million and this is because current experience shows that the States will utilize the program at a rate somewhat in excess of the current availability.

In Public Health, $12,750,000 for health manpower education, and utilization.

Mr. FLOOD. The States have come a long way on vocational rehabilitation, haven't they?

Mr. KELLY. There is still some unevenness among the States, but the program took a long time to reach the level where it could be—that it could produce 100,000 rehabilitations a year. For a long time that was our target.

In 1968 the target is 218,000, which will be a 15-percent increase over this year.

Mr. FLOOD. Some are doing a pretty good job.

Mr. KELLY. Yes, and it is a program that gives you a really high degree of satisfaction because you know that it is not only socially good to allow a man to get back into the labor market, but it is also economically sound. It returns about $7 in taxes for every dollar invested.

The manpower supplemental of $12,750,000, again, is a late enactment of the Allied Health Professions legislation, and is an attempt to increase the manpower available for health purposes.

Air pollution has a supplemental of $3,904,000, and this again was related to legislation enacted in the closing days of the last session of Congress that has not yet been funded.

Mr. KELLY. For the appropriation "Mental Health Research and Services," we are asking $2 million. This is to launch the newly

enacted Narcotics Addiction Act passed in the last days of the last session. It was supposed to be operative February 1, but we haven't been able to fund it.

Comprehensive health planning and services, a supplemental of $4.5 million. In this case the Congress last year passed what we think is landmark legislation for the "Partnership for Health," and among the things provided were planning funds to assist States in laying out a comprehensive program as to what their greatest health needs are, and their plan for utilizing the Federal funds that match the State and local funds.

Mr. FLOOD. Were those programs that varied geographically?

Mr. KELLY. Quite a bit. This was one of the very real virtues of the new act. Until now we had made formula grants for TB, venereal disease, for heart disease control and for mental health. This new program allows each State to determine how it will meet the total problem and health needs of its State.

The amounts of money that were authorized are almost the same as the amounts of money that were available under existing programs and in order to fully accomplish the purpose of this consolidation it is going to have to be a larger program in our judgment.

But, the starting point is to make available to the States planning funds so that you get a full identification as to what the problem in each State is, how they assess it and how they will approach it and then you can come back to the Congress with what we believe will be a more meaningful program related to the various regions of the country.

Now, in addition to the formula grants for States, there are special project moneys available and these moneys allow you to meet the problems that are national in scope and in which the States themselves may not consider the problem to be that great, but the Federal Government considers it to be great. An example may be a communicable disease type problem or a problem that centers in one region of the country, or an area where we are trying to demonstrate a new idea and get it adopted on a national basis.

We have a request before you for $91,103,000 for payment to the trust fund for health insurance for the aged. In this instance we were before you last year and asked for the funds to carry out the health insurance program. However, we underestimated how many people would sign up for the supplementary health insurance benefits and on the basis of having well over 90 percent of the people sign up, in order to match their contribution to the insurance fund, we are asking for a supplemental to put up the Federal share of that insurance fund.

Mr. FLOOD. There isn't much we can do about that, is there?

Mr. KELLY. This is a commitment the Federal Government made in enacting the health insurance program.

Under public assistance, the grants for welfare, we are asking for a supplemental of $470 million. This is larger than had been predicted in the President's budget, and it is larger than the funds I have included in these tables.

Originally we thought that a supplemental of about $282 million would suffice, but current trends——

Mr. FLOOD. You really missed that one. How did that happen?

Mr. KELLY. Well, we were overly optimistic about the trends that would occur in aid to families with dependent children. Our trends

with respect to the aged were accurate; with respect to the blind, they have held fairly constant; and there is a slight increase, although not very different from the estimates, with respect to the permanently and totally disabled.

Mr. FLOOD. How would you miss on this one so badly?

Mr. KELLY. When the legislation was enacted last year in connection with the social security program, we really predicted that both the economy and the changes in the social security program would result in an increase, but a lesser increase in aid to families with dependent children than had occurred in the past.

Actual experience has shown that it is rising at about the same rate as it has in the past, and I think our best explanation for that is that the States have undertaken to more nearly meet the needs of people in their communities than they had been meeting in the past; that they are now in a position where (1) they feel it is a public responsibility, and (2) because of a high economy, are taking advantage of this and trying to fulfill the responsibility and more nearly meet need.

This is shown up in the greater number of States adopting the program for the unemployed parents and the somewhat more liberal provisions in both the budget for individual families and in eligibility and, as you know, this is determined on a State-by-State basis. I would not want to mislead you. In many of the States the payments are still at a very low level.

The other thing that occurred was that the medical assistance program, the so-called medicaid, has two features to it on which we missed the estimate. One is that more States have adopted it and adopted it on a more liberal basis. Thirty of them have adopted it. The provisions of their plans are somewhat more liberal than we predicted.

Mr. FLOOD. Not unlike New York?

Mr. KELLY. Well, in New York—you see, New York, California, and Michigan account for a very substantial portion of the national total. The other thing is, as was brought out in the President's statement the other day, the cost of medical care has risen at a much more accelerated rate than it has in the past and we had not predicted this expense.

The other item of supplemental is that we have a request for $350,000 to launch the new international education program. These are essentially planning funds to get ready for the establishment of this program. This, again, was legislation enacted in the closing days of the last Congress.

1968 BUDGET

(Summary chart follows:)

Department of Health, Education, and Welfare budget in brief

[Dollars in billions]

	1967	1968	Increase
General funds:			
New obligational authority (appropriations)	$12.3	$13.3	$1.0
Expenditures	10.7	11.7	1.0
Trust fund expenditures	25.5	31.0	5.5
Staff (in thousands)	105.0	109.7	4.7

NOTE.—Of the total request for new appropriations $13,085,000 is to carry out existing programs and $179,000,000 is for new programs for which legislative proposals will be submitted shortly. Of the $31,000,000,000 in trust funds, $4,100,000,000 is for increased social security benefits for which legislation will be proposed shortly.

Mr. KELLY. Now, the budget for 1968 proposes $13.3 billion in new obligational authority, an increase of $1 billion. Stated in terms of actual disbursements from the Treasury, it goes from $10.7 to $11.7 billion, or an increase of $1 billion. The difference between the expenditure figure and the new obligational authority figure is because of a lag, on the average, of almost 12 months between the time that you appropriate funds for us to enter into commitments and the time that we actually pay out the funds for those commitments.

In some programs, of course, you pay them out as rapidly as you incur the obligations, such as in payroll.

Mr. NATCHER. In the supplemental, you have how much for the International Education program?

Mr. KELLY. $350,000.

Mr. NATCHER. How much in the regular bill?

Mr. KELLY. It is a figure of $20 million.

Mr. SHRIVER. How will the supplemental be presented? As you are presenting the items for the regular 1968 budget?

Mr. KELLY. No, I would presume you would organize separate hearings and we would take those up one at a time and handle them as a separate set of hearings as soon as you have scheduled them and are ready for them.

With regard to the trust fund expenditures out of the social security trust fund this year we will spend $25.5 billion. We predict the expenditures next year as being $31 billion, an increase of $5.5 billion.

Mr. FLOOD. Is this good?

Mr. KELLY. I think so, and these figures are in accord with the schedule of taxes and are in reasonable actuarial balance as presented in the trustees' report.

PROPOSED LEGISLATION

(Chart on this subject follows:)

1968 Budget under existing and new legislation

[In millions of dollars]

	Appropriations	Trust fund expenditures
Appropriations for existing programs (including extension legislation where required)	13,085	26,864
New programs requiring new legislation:		
1. Education legislation	67	
2. Health and welfare legislation	88	
3. Social security legislation	24	4,140
Total, new legislation	179	4,140
Total, 1968 HEW budget	13,264	31,004

Mr. KELLY. I was going to point out that in the $13,300 million we have included $179 million which is for programs not yet enacted on which the President has recommended legislation and are now under consideration by the Congress.

In the $31 billion we have $4.1 billion for the legislative proposal that the President has submitted and on which the Ways and Means

Committee is now holding hearings; that legislation, as you will recall, increases average benefits by 19 percent, but it also increases the wage base upon which the tax is predicated.

Mr. FLOOD. That was a proposal?

Mr. KELLY. Yes, but I have included them in here. There is $179 million here that is new legislation.

DEPARTMENTAL STAFFING

Now, in terms of departmental staffing, the authorized permanent positions for this fiscal year are 105,000 and for the 1968 budget we have proposed 109,700. This is almost entirely workload related expansion, as in the case of the Social Security Administration, or as in the operation of hospitals and the administration of enlarged grant programs.

Now, just briefly referring to the expansion in legislation which I mentioned, of the $179 million worth of new legislation, $67 million is in the educational field. The important characteristic of the legislation in the educational field is the concept of providing, as we are doing in health, State educational agencies with planning funds that permit them to organize and establish the basic programs for that State.

In the health and welfare legislation, we have an increase of $88 million.

STATE PLANNING

Mr. FLOOD. You were looking forward to the day when every State will have a so-called basic plan in education and in vocational rehabilitation.

Mr. KELLY. And health, and in social services.

We think a great deal of work has already been done in the development of planning of physical resources, in land-use planning, and in urban renewal planning, but when you get to the question of State and community planning for social services, it is a much neglected area. We feel that the concept that was built in the partnership for health legislation last year has a great promise of bringing the Governor and his key staff more nearly into the control of his State's programs and the decision on how you allocate resources by the creation of plans, that take into consideration the whole range of possibilities and needs of that community and the necessity for making some hard choices as to which of the areas has the highest priority. We also think that some of the concern that has recently been expressed about the narrow categories of our Federal programs really are met by giving an aid to such State planning.

Mr. FLOOD. Those are plans that will be made up by the several States.

Mr. KELLY. Within a framework of assistance in establishing planning machinery and an identification of the kinds of needs and areas of national interest that the Federal Government has identified a concern with, yes, sir.

GOVERNORS RESPONSIBILITIES

Mr. SMITH. What has this to do with Governors being given greater authority by their States and a better opportunity to exercise their responsibilities?

Mr. KELLY. I said one of the things that gave rise to the Congress enacting the partnership for health program last year was the fact that there have been a continuous series of discussions about the difficulties that States encounter when the Federal Government provides them a small category of funds for heart disease control, another one for cancer control, another for mental health, another one for tuberculosis, another for venereal disease, and when these are formula grants, they start from an assumption that the problem bears an almost exact relationship to population. The law enacted last year merged the series of formula grants into a single formula grant and makes it dependent upon the State developing a plan——

Mr. FLOOD. I think you have missed Mr. Smith's point. You upset him and me a little bit and I think everybody else. You seem to stress the dominance of the Governor of the State. That wasn't very clear. You gave the impression that the Governor was going to be some sort of minor diety in this. That "He" was going to do this. Do you mean that?

Mr. KELLY. We have a very strong partnership with the States now.

Mr. FLOOD. I understand that. The State.

Mr. KELLY. Right. We are probably the preponderant agency in working with the States on grants programs.

Mr. SMITH. But, isn't it true that in very few States has the Governor had much authority to administer the programs in the field of health, education, and welfare?

Mr. KELLY. They are having, I believe, Mr. Smith, an increasing participation. For example, this partnership for health program requires that the Governor create or designate the agency that is going to do the health planning.

Mr. FLOOD. Yes, I remember that.

Mr. SMITH. But he usually designates the State agency and that is the last oversight control he has over it. That is one of the usual weaknesses in our State government system.

Mr. KELLY. I think this is true of the operation of these programs, but I would think if he designates a planning agency, that that planning agency will be required to report to him and present the plan to him and he has an opportunity to participate there as much as he wants to participate. This is as distinguished from designating an agency just for operation of a program. Here he has got to plan and submit his approved plan before operations begin so it would seem to me that he would increase his participation.

DISTRIBUTION OF THE BUDGET BY PROGRAM

Appropriations by program

[In millions of dollars]

	1967	1968	Increase
Elementary and secondary education	$2,276	$2,599	$323
Higher education (excluding construction)	672	755	83
Higher education facilities construction	723	452	−271
Other support for education	278	361	83
Health manpower	393	467	74
Health services and facilities	963	1,124	161
Financing health care	1,985	2,148	163
Disease prevention and environmental control	197	235	38
Consumer protection	64	68	4
Biomedical research	1,208	1,293	85
Other health activities	50	56	6
Public assistance and other welfare activities (excluding health assistance)	3,163	3,295	132
Vocational rehabilitation	328	388	60
General administration	17	23	6
Total	12,317	13,264	947

Mr. KELLY. We have identified here some of the key items that make up the preponderance of the Department's budget and thought that we would array it for you in a manner which would help you see how the $13,300 million will be used.

Of this, $2,600 million is in elementary and secondary education. Now, $1,700 million is for the recently enacted Elementary and Secondary Education Act. Almost $500 million of it is a continuation of the Federal impacted area aid program.

Mr. FLOOD. Have you heard anything about a proposal for an additional $500 million for elementary and secondary education?

Mr. KELLY. Not quite in that way. When the Congress enacted the extension of the Elementary and Secondary Education Act last year, they authorized a program which, on title I alone, had an authorization under the formula of $2,400 million.

We have asked in this budget only for $1,200 million so that it is just half of the authorization. The authorization expires at the end of 1968 and the Congress is considering an extension of that legislation. Hearings on the proposed legislation have begun, and the Education and Labor Committee in the House evidenced substantial concern that they had enacted an authorization of this magnitude and that it was not being funded to that extent.

I think that the fiscal constraints that surround this budget have occasioned it to be at a lesser level than the amount authorized. I also think that prudence in getting the program well organized and well established before it is fully funded would require us to conclude that we ought to take our steps more slowly than doubling the program in one fell swoop, but the committee did authorize such a doubling and the budget does not fully fund it. As a matter of fact, it funds an increase of $147 million in 1968 over the 1967 level.

In higher education, exclusive of construction, we are asking for $755 million, an increase of $83 million. This includes the opportunity grants, the student loans work-study, and college teacher training.

HIGHER EDUCATION CONSTRUCTION

Under higher educational facilities, we are asking for $452 million. This item appears in the budget as a reduction of $271 million; $200

million of that reduction relates to a conversion of the method of handling higher education loans from a direct appropriation to the use of receipts from the participation pool sales. In order to do that, we need congressional authorization.

Mr. FLOOD. You ultimately want to go to the private sector entirely?

Mr. KELLY. As much as possible; yes.

Mr. SMITH. That would be a net reduction of $71 million?

Mr. KELLY. That is correct, and even here the amount of construction put in place, the obligations and the start of construction in 1968 we predict as being higher than in 1967, because during this fiscal year, as a result of the cost reduction program, we are slowing down the level of construction starts to avoid the inflationary impact of a construction program of the size of ours.

Mr. SMITH. You are saying the reason for the $71 million reduction is to cool off the construction segment of the economy?

Mr. KELLY. To put it another way, we cooled it off this year and have moved funds from this year to next year and will have a substantial amount on hand for that purpose, but we still want to continue to initiate new projects.

Mr. SMITH. The action level then will not be reduced?

Mr. KELLY. The action level will be accelerated.

Mr. CARDWELL. There is one distinction between the two figures. The $200 million to which Mr. Kelly refers is construction loans and the $71 million comes against construction grants but, as he points out in the grant area, there is already in the pipeline money which will enlarge construction starts supported by grants in 1968 over 1967 even with a reduction in Federal grants.

Mr. SMITH. Does this decrease the proportion of grants in the mix as compared to loans?

Mr. CARDWELL. Yes, it does.

Mr. KELLY. But not very much. The redistribution will be fairly minor.

Mr. SMITH. You say fairly minor. It is 3 or 5 percent?

Mr. KELLY. If you take the total of $723 million and change it by $71 million, you get a 10 percent overall reduction in new funds. The relationship of grants to loans now is 5 to 2. We are decreasing the five by $71 million so it will end up 4.5 instead of 5 to 2. For all other educational activities, we are requesting $361 million, an increase of $83 million. This category, among other things, includes the extension of the educational TV program and includes the support of special institutions like Howard University and Gallaudet College and the American Printing House for the Blind.

In the health manpower area, we have an increase of $74 million to $467 million. This will help produce an increased supply of doctors dentists, auxiliary personnel, and nurses, through support for additional scholarships, fellowships, student loans, and assistance for the support of the schools themselves.

Under health services and facilities, we have an increase of $161 million to a total of $1,124 million. As you know, we provide funds for the construction of hospitals, the mental health facilities, and similar activities designed to increase the availability of services, nursing homes, hospitals and the like.

Mr. CARDWELL. That category also includes the partnership for health programs at $168 million.

Mr. FLOOD. You have services and bricks and mortar.

Mr. KELLY. Yes, sir.

In the financing of health care, we have $2,148 million. This category consists of both medicaid and medicare and I will identify those more fully as I go along.

In the area of disease prevention and environmental control we are requesting $235 million, an increase of $38 million. In this category we have air pollution, the program of solid waste disposal, veneral disease control, etc.

Under consumer protection we are requesting $68 million, and this is the program of the Food and Drug Administration.

In the area of biomedical research, the budget estimate is $1,293 million, an increase of $85 million. This is all of the National Institutes of Health and the major portion of the Mental Health Institute.

The category, all other health activities, consists of such activities as the Library of Medicine, the maintenance of health statistics and the administrative expenses of operating the Office of the Surgeon General.

In the area of public assistance and other welfare activities exclusive of health expenses, we are budgeting $3,295 million, an increase of $132 million. The increase is primarily related to the predicted continuing rise in the number of recipients under the aid to families with dependent children program.

In vocational rehabilitation, we have an increase of $60 million and here we expect to reach 218,000 rehabilitants, an increase of 15 percent over this year.

For overall general administration, we are requesting $23 million.

BUDGET BY OPERATING AGENCY

(Chart on this subject follows:)

Department of Health, Education, and Welfare budget by operating agency

[In millions of dollars]

	1967	1968	Increase
General funds:			
Food and Drug Administration	$64	$68	$4
Office of Education	3,902	4,055	153
Vocational Rehabilitation Administration	328	388	60
Public Health Service	2,607	2,923	316
St. Elizabeths Hospital	12	10	−2
Social Security Administration	1,029	1,036	7
Welfare Administration	4,291	4,619	328
Administration on Aging	10	18	8
Special institutions	27	55	28
Other	47	92	45
Total, general funds	12,317	13,264	947
Trust fund expenditures	25,452	31,004	5,552

Mr. KELLY. In the next chart, we just show you the same group of items arranged by the operating agencies of the Department. The budget for the Food and Drug Administration is $68 million; for the Office of Education $4,055 million; the Vocational Rehabilitation Administration, $388 million; the Public Health Service, $2,923 million; and St. Elizabeth's Hospital, $10 million. The reduction shown here for St. Elizabeth's is primarily because of a nonrecurring

construction item. The actual cost of the hospital's program will rise slightly. However, the District of Columbia share of it also rises slightly.

The other agency budgets are: Welfare Administration, $4,619 million; Administration on Aging, $18 million; special institutions, such as Howard University, Gallaudet College and others, $55 million. The large increase for the special institutions is occasioned this year by our asking for funds to construct the new teaching hospital at Howard University. It has been long planned to replace Freedmen's Hospital with a new Howard University teaching hospital and we have now reached the point where we are asking for the construction money for it. The budget for all other activities is $92 million. You will notice that of the $1 billion increase, $153 million is in the Office of Education; $316 million is in Public Health, and $328 million in the Welfare Administration.

MAJOR CHANGES IN EDUCATIONAL PROGRAMS

(Chart on this subject follows:)

Major changes in 1968 budget under existing or extension legislation

[Appropriations—Dollars in millions]

Education programs	1967	1968	Increase
1. Aid for educationally deprived children (title I, ESEA)	$1,053	$1,200	$147
2. Supplementary educational centers and services (title III, ESEA)	135	240	105
3. National Teachers Corps	20	36	16
4. Teacher education	179	210	31
5. Preschool and school programs for the handicapped (title VI, ESEA)	3	15	12
6. Higher education student aid (scholarships, loans, and work study programs)	485	535	50
7. Adult basic education	29	44	15
8. Civil rights educational activities	8	30	22
9. Educational research	92	105	13
10. Higher education for international understanding	17	37	20
11. Special institutions	27	55	28
12. Impacted area aid	439	439	----------
13. Equipment and minor remodeling (title III, NDEA)	83	50	−33
14. Construction grants for undergraduate and graduate facilities	513	440	−73
15. Conversion of construction loan program to participations sales financing	201	3	−198
(Program level)	(200)	(200)	----------

Mr. KELLY. I have identified for you certain of the educational programs that I thought you might want to look at separately and account for the large change.

We discussed title I of the Elementary and Secondary Education Act. We are asking for $1,200 million, an increase of $147 million, but only one-half of the amount of the new authorization. This restraint was applied for the reasons that I outlined for you.

For the supplementary educational centers, which is the special projects part of the Elementary and Secondary Education Act, we are asking for $240 million, an increase of $105 million. This is in order to accelerate the application of new knowledge, and the testing and perfecting of the areas of development. It is available on a formula basis to all of the States.

For the Teacher Corps, we are requesting $36 million, which is an increase of $16 million. As I indicated, we are asking for a supple-

mental in order that we can recruit a spring class for the Teacher Corps.

For teacher education, we are asking for $210 million, an increase of $31 million, with a recognition that this is an acute area of shortage in the United States.

We are asking for $15 million for the first full year of operation of the newly established program for the handicapped which was enacted by the Congress last year. The authorization was much larger than this, but we felt that it was important to get it launched and started in this fiscal year.

For higher education student aid, including the scholarships, loans, and work-study programs, we are asking for $535 million, an increase of $50 million.

For adult basic education, we are asking for $44 million.

Mr. LAIRD. You don't have the money for your vocational education work-study program transferred over there?

Mr. KELLY. HEW reflects no funds for vocational education work-study this year, in accord with the same agreement that we had last year, that we would phase it into the OEO neighborhood youth program.

As the Secretary indicated to you, we are including in the study which this committee directed last year, a study of the long-range handling of that problem.

Mr. LAIRD. That study should have been started months ago.

Mr. KELLY. We are doing a substantial amount of staff work in preparation for the committee coming on board.

The adult basic education program which this year you took out of the Office of Economic Opportunity's program, and assigned to us, is proposed for expansion by $15 million.

Civil rights educational activities, this is title IV of the Civil Rights Act and is heard by the State, Justice, and Commerce Subcommittee. They suggested that we ought to arrange to have it heard by this committee. It is an increase of $22 million, bringing it up to $30 million. This is an effort to make grant funds available and training funds available in order that school districts desiring to bring about a desegregation of their school program can have funds for planning, for the in-service training of their personnel, and for sending their personnel away to school in order that they can become more proficient as a means of bringing about desegregation and dealing with the problems that grow out of it.

Mr. CASEY. You don't have any choice now, do you, if they want to stay in business?

Mr. KELLY. They have to accomplish it.

Mr. CASEY. You said "desire." They haven't any choice, have they?

Mr. KELLY. They may feel that they are perfectly capable of doing it without any help. This program is designed for those who feel that it would be helpful to them to get technical assistance, to create a planning mechanism, organize a training program, or to send their people away to school. The desire I referred to was the desire to apply for these kinds of funds.

Mr. SMITH. Have programs administered by VISTA any relationship to your figures there?

Mr. KELLY. No, they do not, and the Congress, in the last session, authorized a program that recognized that there is a substantial neglect of the handicapped in the public educational systems and actually authorized a program of $150 million a year and created a new Bureau of the Handicapped within the Office of Education.

We are coming up asking for a supplemental of $2,500,000 this year in order to plan and organize it with the States.

Mr. SMITH. Do you contemplate taking over some of the work the District is now doing, or are you going to completely supplement what they are doing?

Mr. KELLY. I don't really know the answer to that question. However, I would say that if we could establish and get an effective operation in the public school system throughout the Nation that adequately dealt with the problem of the handicapped, that there would probably be no problem with OEO since their whole attitude is that if you can build this into basic structure, then you have accomplished their objective and they can fade out of it.

Mr. CARDWELL. Title VI authorizes grants to the States through school districts to carry out their programs.

Mr. KELLY. We have a request before you for $105 million in connection with educational research, an increase of $13 million. That is a substantial growth in recent years. It is an identification that the huge expenditures made on education in the United States are very poorly supported with a research base and this is an attempt to increase the supply of research manpower, to support the research which is now being conducted in areas of excellence and to create new research institutions that bring multidiscipline organizations into the educational research field and into the dissemination of research findings.

In "Higher education for international understanding," we have $37 million, an increase of $20 million. This item includes, under the Assistant Secretary for Education, the center for educational cooperation, which brings together the programs now lodged in the Office of Education that deal with foreign language studies and area-wide studies, and the new international education program that has as its view strengthening American universities to be more capable in developing scholars and developing in people knowledge of world affairs.

For the "Special institutions," we are requesting $55 million. These are Howard University, Gallaudet College, American Printing House for the Blind, the National Institute—the National Technical Institute for the Deaf, and the new Model Secondary School for the Deaf here in the District of Columbia, with the big increase being for construction of the hospital at Howard University.

IMPACTED AREA AID

"Impacted area aid" at $439 million is an exact continuation of the level of appropriations made this year. You may recall that last year there was recommendation for substantial cutback. It was controversial and the cutback was restored. The policy underlying this budget is not to endeavor to make a precipitous reduction until the whole problem of the national policy of support of Federal impact areas has reached a long-term solution, but to restrain it to its present

level with the thought that any increase that can be afforded in budgeting for elementary and secondary education should go into the new Elementary and Secondary Education Act.

Mr. LAIRD. The impacted area program is funded at 90 percent of entitlement?

Mr. CARDWELL. That is right. I can give you the authorization.

Mr. LAIRD. So, what you are doing is cutting the program 10 percent; is that right?

Mr. KELLY. We are holding it to the present level and it would take 10 percent to pay full entitlement.

Mr. SMITH. How much of that is category A?

Mr. KELLY. The only legislation which expires is the legislation for construction of facilities. The construction part for A is permanent, and it would take about $35 million if B were extended. But both A and B are below the entitlement level under the statute for "Operation and maintenance."

Mr. SMITH. How can you cut A?

Mr. KELLY. You can't. Under "Operation and maintenance," you can't distinguish between A and B. You make the count of A children and multiply it out. You make the count of B children and multiply it out and it equals so much as your entitlement. If your appropriation is less than all of the entitlements, then you prorate it so the B children are just as much affected by this proration as A children, and vice versa.

Mr. CARDWELL. The 1968 authorization for maintenance and operation would be $461.5 million compared to $416.2. The difference between $416.2 million and the $439 million is in construction.

Mr. SMITH. Who pays the bill for category A children on Federal reservations then if there isn't enough Federal money?

Mr. KELLY. The local school district.

Mr. SMITH. On A category?

Mr. KELLY. On A and B.

Mr. LAIRD. Under the present proposal, the additional 10 percent is to be taken up by local real estate taxes, is that right?

Mr. KELLY. Yes, sir.

Mr. CARDWELL. The dollar level for operations and maintenance in 1968 is the same as was approved by Congress for 1967.

Mr. KELLY. The construction grants for both graduate and undergraduate facilities is $440 million. It is $73 million less than this year's level and that is the item we discussed a few minutes ago.

In the conversion of the loan program from direct appropriations to the use of the participation pool arrangement, the same program level will be maintained but it is a decrease in appropriations request of $198 million.

Mr. SMITH. The A students live on base and the parents work on base. A local school district is not liable for their support.

Mr. KELLY. If the local school district does not provide them education and we have to provide it ourselves, then we would build and operate a school on base and, of course, we would have to pay 100 percent of that.

Mr. SMITH. Does that category have a priority?

Mr. KELLY. That is the first thing you pay for, the ones you directly operate.

Mr. LAIRD. That costs you a lot more too.

Mr. CARDWELL. The figure on payments to other Federal agencies for 1968 is $27 million, which is an increase of $2.5 million over 1967.

MAJOR CHANGES IN PUBLIC HEALTH PROGRAMS

(Chart on this subject follows:)

Major changes in 1968 budget under existing or extension legislation

[Dollars in millions]

Public Health Service programs	1967	1968	Increase
1. Construction grants for health educational facilities	$160	$203	$43
2. Scholarships for health personnel	5	13	8
3. Health educational improvement grants	30	57	27
4. Indian and migrant health programs	99	113	14
5. Comprehensive health planning and services	124	144	20
6. Hospital construction activities	283	308	25
7. Programs to control air pollution	40	66	26
8. Regional medical programs to combat heart disease, cancer, and stroke	45	64	19
9. Construction grants for health research facilities	56	35	−21
10. National Institutes of Health (excludes regional medical programs and health research facilities)	1,010	1,088	78
11. National Institute of Mental Health	308	347	39

Mr. KELLY. In public health, the items that make up the budget are: We have $203 million for construction grants for health educational facilities, an increase of $43 million.

This is the program where we are trying to increase the number of schools that are preparing physicians, dentists, and other health personnel to augment the current undersupply.

We have scholarships for health personnel in the amount of $13 million, an increase of $8 million.

The health professions educational improvement grants which are assigned to assist the health professional schools in increasing the quality of their programs is $57 million, an increase of $27 million.

For the Indian and migrant health programs, $113 million, a $14 million increase.

For the "Comprehensive health planning and services," $144 million. Comprehensive health planning and services are the figures associated with the partnership for health program which we discussed a little while ago in which the State will do the planning and then these funds are available.

Hospital construction, $308 million, an increase of $25 million. That is the full authorization. The program to control air pollution, $66 million, an increase of $26 million and that is the full authorization for that program. The regional medical programs to combat heart disease, cancer, and stroke, $64 million, an increase of $19 million. This is substantially below what we had earlier predicted to be the level that we would achieve.

Mr. FLOOD. Is there much action on that?

Mr. KELLY. There has been a very substantial effort related to planning. We have just now made five operational grants. For the

first time the program has moved from the planning stage to the operational stage.

The fiscal year 1968 program anticipates——

Mr. LAIRD. You have been kind of dragging your feet on approvals to keep it at a low level, have you not?

Mr. KELLY. No, I think there has been a real effort.

Mr. LAIRD. You haven't gotten any place near what you anticipated at this time last year when you testified before this committee.

Mr. KELLY. That is right. I think there has been a real effort to make sure we did not get this program started on the basis of just putting out funds for plans developed around the country, but rather we have tried to use an advisory committee to identify how this program could best fulfill its purpose of extending the capability and knowledge already existing within the large medical complexes to community hospitals and also to provide a continuing education program. I think that the planning will pay off.

Mr. LAIRD. You should smile once in a while when you give an explanation like that.

Mr. KELLY. On the construction grants for health research facilities, $35 million, a decrease of $21 million. In this area, as in higher education, the actual number of construction starts in 1968 will be greater than in 1967. This is because construction starts are being held back this year as a part of the cost reduction program. In the case of the National Institutes of Health, we have a request for $1,088 million, excluding the regional medical program and the Health research facilities program, an increase of $78 million; and for the National Institutes of Mental Health, $347 million, an increase of $39 million.

MAJOR CHANGES IN WELFARE, REHABILITATION, AND AGING PROGRAMS IN 1968 BUDGET

(Chart on subject follows:)

Major changes in 1968 budget under existing or extension legislation

[Appropriations—Dollars in millions]

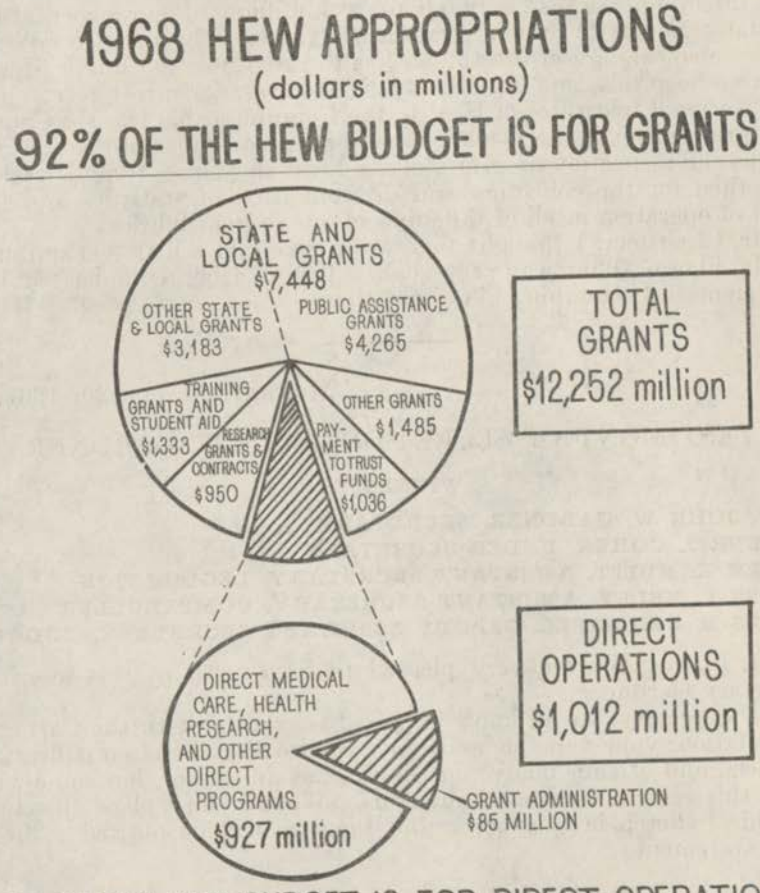
Welfare, rehabilitation, and aging programs	1967	1968	Increase
1. Medical assistance (under title XIX and other public assistance titles of the Social Security Act)	$1,061	$1,253	$192
2. Public assistance (excluding medical assistance)	2,921	2,987	66
3. Child health programs	174	183	9
4. Vocational rehabilitation	328	388	60
5. Coordination and development of programs for the aging	10	18	8

Mr. KELLY. For medical assistance under all the public assistance programs, including title XIX and the amounts that are being spent under old programs pending States' adopting title XIX, the amount requested is $1,253 million, an increase of $192 million. This is the area I have discussed where we have both rising costs and increased number of States that are adopting the title XIX. This estimate assumes 48 States will be in operation in 1968. Public assistance, excluding medical care is $2,297 million, an increase of $66 million. For the child health programs, the crippled children's program, the program for maternity and infant care, and so on—

we are requesting $183 million, an increase of $9 million. Vocational rehabilitation we covered, an increase of $63 million. The coordination and development of programs for the aging, $18 million, an increase of $8 million.

GRANTS AND DIRECT OPERATIONS IN BUDGET

(Summary chart follows:)



Mr. KELLY. The last chart I have just points out the makeup of the HEW budget. I thought it might be helpful to you to show that out of the $13.3 billion, $12,252 million will go out in the form of grants and contracts, and $1,012 million will be for the operations for which we employ people and engage directly. Of the amount which goes out in the form of grants, $7,448 million is for grants to States and local agencies and $4,265 million of that is for public assistance and $3,183 million for all other purposes.

We estimate that $1,333 million will be for training grants and student aids; $950 million for research grants and contracts; $1,036 million for payments into the trust fund to cover the responsibilities that the Social Security Administration has assumed for matching supplementary health benefits and for those people who do not have social security coverage; $1,485 million is earmarked for other grants, of which about $1,200 million is for construction grants and about $300 million is for demonstration and special projects. In terms of the direct operations, only about $85 million of our expenditures actually go for the administration of grants. The balance goes for direct medical care in the Indian health programs, the Public Health Service hospitals, and St. Elizabeth Hospital; for direct research at the National Institutes of Health, the Communicable Disease Center, and other parts of the Department; for the consumer protection programs and inspection programs of the Food and Drug Administration; and then for the collection and dissemination of statistics and this kind of operation in all of the areas of our responsibilities.

Mr. Chairman, I thought this would give you a little background.

Mr. FLOOD. That was very good. This is a big, complicated Department and something like that helps.

MONDAY, MARCH 20, 1967.

TESTIMONY OF SECRETARY JOHN W. GARDNER

WITNESSES

HON. JOHN W. GARDNER, SECRETARY
WILBUR J. COHEN, UNDER SECRETARY
RALPH K. HUITT, ASSISTANT SECRETARY, LEGISLATION
JAMES F. KELLY, ASSISTANT SECRETARY, COMPTROLLER
JAMES B. CARDWELL, DEPUTY ASSISTANT SECRETARY, BUDGET

Mr. FLOOD. We are very pleased to have with us this morning Secretary Gardner.

Mr. Secretary, we all know of your background with the Carnegie Foundation, your valuable assistance to two Presidents on education matters, and of your many contributions as an author, but some who read this record may not know this. We will first place this biographical sketch in the record and then we will be pleased to hear your statement.

BIOGRAPHICAL SKETCH OF JOHN W. GARDNER

John W. Gardner, Secretary of Health, Education, and Welfare, was president of the Carnegie Corporation of New York and of The Carnegie Foundation for the Advancement of Teaching at the time of his appointment to the Cabinet by President Johnson on July 27, 1965.

He was born in Los Angeles, California, in 1912.

He is an Honorary Fellow of Stanford University where he received his A.B. and M.A. degrees. He received his Ph. D. degree at the University of California and holds honorary degrees from numerous colleges and universities in the United States and Canada.

Before World War II, Mr. Gardner taught psychology at Connecticut College for Women and Mount Holyoke College.

In 1942, Mr. Gardner served as chief of the Latin American Section of Foreign Broadcast Intelligence Service of the Federal Communications Commission.

The following year he joined the U.S. Marine Corps and was assigned to the Office of Strategic Services. He served with the OSS in Washington, Italy, and Austria. At the time of his release from active duty, he held the rank of Captain.

Mr. Gardner joined the Carnegie Corporation in 1946 as executive associate. He became president in 1955, and the same year was made president of The Carnegie Foundation for the Advancement of Teaching.

He has at various times served as consultant to the U.S. Delegation to the United Nations, the Air Force, the Department of Defense, the Agency for International Development, the U.S. Office of Education, and the White House. He served on the Special Task Force on Education established by President Kennedy shortly after his election in 1960. He was chairman of the U.S. Advisory Commission on International Educational and Cultural Affairs (1962–1964), President Johnson's Task Force on Education (1964), and of the White House Conference on Education (1965).

Mr. Gardner holds the U.S. Air Force Exceptional Service Award, and in 1964 was awarded the Presidential Medal of Freedom, the highest civil honor in the United States.

Prior to his appointment, Mr. Gardner served as a member of the board of the Metropolitan Museum of Art and the American Association for the Advancement of Science; and is a fellow of the American Psychological Association and of the American Academy of Arts and Sciences. He is a member of the Council on Foreign Relations and the Society of Sigma Xi.

As chairman of the Panel on Education of the Rockefeller Brothers Special Studies Project, he was chief draftsman of the report, *The Pursuit of Excellence.* He is the author of the chapter "National Goals in Education" in the report of President Eisenhower's Commission on National Goals (*Goals for Americans*) also wrote the chapter "Can We Count on More Dedicated People?" in the book *The National Purpose.* He is the editor of President John F. Kennedy's book *To Turn the Tide.* He is the author of the books *Excellence: Can We Be Equal and Excellent Too?* and *Self-Renewal: The Individual and the Innovative Society.*

GENERAL STATEMENT

Secretary GARDNER. Mr. Chairman, it is a pleasure for me to appear before this committee to present the 1968 budget for the Department of Health, Education, and Welfare.

In his special message on education and health, President Johnson said:

> I do not recommend more of the same—but more that is better: to solve old problems, to create new institutions, to fulfill the potential of each individual in our land.

This statement also applies to the President's budget recommendations for the Department of Health, Education, and Welfare.

OVERALL VIEW OF THE DEPARTMENT

Before getting into specific programs, I would like to discuss with you some general characteristics of the Department's programs and how we administer them.

Despite the variety of the programs Congress has assigned to our Department, they share many common features. They are intended to strengthen the individual—either by direct assistance through such programs as social security or indirectly by strengthening institutions that serve him such as the university or the community hospital.

Another feature common to our programs is that they rely heavily on non-Federal institutions and State and local initiative. For example, when the objective was to provide medical care to the aged, Congress did not establish a national hospital system for old people. Rather, an insurance program was authorized to provide the aged with the means to purchase medical care from the existing hospital

and health services system. This arrangement helps the aged and—because it sets high medical standards and covers the full cost of care—will, we believe, strengthen the Nation's private health services system. The research programs of the National Institutes of Health rely far more on universities and private research institutions than on direct Federal research activities. The Federal program of aid to elementary and secondary education depends entirely on the initiative of States and local school districts. This theme of interdependence runs through everything that we do.

CREATIVE FEDERALISM

Federal programs have utilized non-Federal institutions for a long time. The nature and magnitude of the programs we are now engaged in make it imperative that we strengthen these relationships. President Johnson has called this endeavor "creative federalism." In our Department we are doing everything possible to bring about a more effective working relationship with State and local government.

For example, the "Partnership for Health" authorized by Congress last year is designed to strengthen State health planning and administration, and to provide the State with greater flexibility and opportunity for initiative than it has had in the past. A mutual dependence forms the basis for this partnership. The Federal Government depends on State health departments to realize national goals. At the same time, State health departments depend on the Federal Government to help them achieve State and local goals. Similarly, grants to strengthen State departments of education were authorized by the Elementary and Secondary Education Act. Legislation already submitted to the 90th Congress would broaden this assistance by authorizing comprehensive State educational planning.

MANAGEMENT IMPROVEMENT

In recent years, the Department has made a number of efforts to modernize its administrative machinery. Three operating agencies, the Social Security Administration, the Office of Education, and the Public Health Service have been thoroughly reorganized to improve program operations as well as to accommodate new responsibilities.

One aspect of reorganization is directly related to creative federalism—namely, a move toward decentralization. For example, in order to administer the partnership for health, much of the responsibility for review and approval of plans and grants will be delegated to the regional health director, thus bringing decisionmaking closer to the scene of operations. This approach will be extended to other health programs. The Office of Education is establishing a field organization to bring its programs into a closer working relationship with school districts and State departments of education. Extending this approach to the Department as a whole, we are placing more responsibility and authority with the HEW regional directors.

PROGRAM PLANNING AND COORDINATION

In recent years, greater attention has been paid to coordination because the problems to be solved cut across agency lines. For

example, effective administration of the health insurance program involves the Welfare Administration and the Public Health Service, as well as the Social Security Administration.

Our newest effort at improving coordination is the Center for Community Planning recently established in the Office of the Secretary. The main function of the Center will be to coordinate the Department's programs which affect urban areas. We now administer many such programs but they have lacked a point of focus. This has created problems for the cities and has made departmental administration and evaluation more difficult. The new Center will develop goals for the Department's urban programs, coordinate research and demonstration activities, and work with other Departments, particularly the Department of Housing and Urban Development.

Last year we had our first experience with the new planning programing, and budgeting system. This system permits programs and their interrelationships to be analyzed, and permits alternative program proposals to be tested against costs and measurable benefits. We are improving our ability to use this new tool. It will play a major role in evaluating our current programs and developing new proposals.

CIVIL RIGHTS

I would like to mention one more topic of general significance for the Department—title VI of the Civil Rights Act of 1964. This title prohibits discrimination in federally assisted programs and consequently, has a broad impact on our Department. When the issue of noncompliance arises, our objective is to work with States and institutions to help them come into compliance. In this way we seek to avoid the kind of confrontation that leaves the Government no choice but to invoke the sanctions required by the act.

Last year much of our civil rights effort was to assist hospitals and nursing homes qualify for participation in medicare. Private agencies such as the American Hospital Association and the American Nursing Home Association cooperated in the effort. As a result more than 95 percent of all hospitals and 96 percent of all nursing homes are officially committed to providing services without discrimination.

There has also been progress with southern school districts. The percentage of Negro children attending desegregated schools in the 11 Southern States rose from 6 percent during the previous school year to 12.5 percent during the current year. Nearly half the school districts in the South have made a start on the desegregation of faculty.

Despite this progress, our work is far from finished. Title VI regulations, as approved by the President, require on-site visits to verify assurances of compliance. Although assurances have been received from all agencies and institutions receiving assistance, we have not had the manpower to visit more than a fraction.

Our budget for 1968 requests additional resources to carry out our responsibilities under title VI. Most of the new positions we are requesting are for working with States and other grant recipients to facilitate their compliance with the law. We want to administer the law with the greatest possible fairness to all concerned, and it's hard to accomplish that without enough people to do the job right.

We are now operating successfully under the central financial management established by last year's appropriation act. The development and coordination of overall policy is firmly in the hands of my special assistant for civil rights. All legal enforcement procedures have been centralized in the Office of the General Counsel. However, I continue to place primary responsibility for negotiation and assistance with the heads of the operating agencies. This organizational arrangement has proved to be effective. I believe that it will continue to be effective in the future.

EDUCATION

During the course of these hearings, all of our programs will be carefully examined. Right now I would like to review some of our major programs and discuss with you some of the issues involved in them.

Our national goal in education is to create a system that provides opportunity for every individual to develop his talents fully. We have a long way to go before reaching that goal. Huge disparities exist among schools and colleges in various parts of the country and often within the same State. Economic, cultural, and ethnic factors still count heavily for or against an individual's opportunity to realize his full potential.

The Department's role is to work with the States and the educational community to strengthen this country's system of education and expand individual opportunity. The great legislation of the 88th and 89th Congresses opens the way for us to attack the Nation's educational problems. The budget we are presenting here today provides resources which will lead to their ultimate solution.

PRIMARY AND SECONDARY EDUCATION

The Elementary and Secondary Education Act has provided some remarkable new tools for improving the Nation's school system. This law calls for innovation and challenges the States and local communities to find solutions to their own problems.

Title I is particularly designed to aid the disadvantaged schoolchild. This year over 70 percent of the 25,000 eligible school districts will participate in the program and over 9 million underprivileged children will be benefited. More than 19,000 individual projects will get underway during the year. Typically these projects have supported improvements in the teacher-pupil ratio, provided books and instructional equipment in impoverished schools, and permitted school districts to hire teacher aids.

Despite the promise that this program holds, we are proposing that it be funded at about half the amount authorized for 1968. We are recommending this course of action for two reasons. First, with the strains imposed by the war in Vietnam, spending the full authorization would tend to aggravate inflationary pressures in our economy. Besides causing general economic problems, such inflation would mean that the country would be buying less educational improvement for each Federal dollar invested. Second, and more important, there is considerable doubt that our existing educational system can efficiently utilize such a large infusion of money. One essential element

in the strengthening of the Nation's educational system is building up its capacity to absorb new ideas and methods. This capacity cannot be created overnight.

For these two reasons we chose not to move forward as fast as the legislative authorization would have permitted. However, we are moving forward. The $1.2 billion we are requesting will buy a substantial amount of educational improvement in 1968. Furthermore, the impact of this assistance will be augmented by the supplementary educational centers and services available under title III of the act. These permit school districts to strengthen the regular school curriculum and develop innovative approaches to solving educational problems. Other programs are directed toward augmenting library resources and improving the counseling of students. This budget will provide the resources to make 1968 a year of progress for the Nation's elementary and secondary schools.

SPECIALIZED ASSISTANCE PROGRAMS

Besides general assistance to States and school districts, we administer a number of programs directed toward special educational problems. One of the most important of these is vocational education. The young men and women now in school must be given the skills that will allow them to compete in the modern world. The Department helps the States improve their vocational education programs by hiring more teachers, buying specialized equipment, offering new courses, and renovating facilities. The schools must keep up with technological advances.

The program of adult basic education also has a vocational purpose. Jobs for the illiterate are being automated out of existence. In 1968, this program will reach 400,000 people, 50,000 of whom will be participating in experimental projects designed to develop new approaches to teaching illiterate adults.

Last year's elementary and secondary education amendments gave renewed emphasis to developing improved educational programs for the handicapped at the preschool, elementary, and secondary school levels. Planning for these programs will begin this year, and in 1968 we will hope to bring improved educational programs to approximately 100,000 handicapped children.

TEACHER CORPS

One of the most promising approaches to helping the deprived school child is the Teacher Corps. The major obstacle to educating deprived children is getting an adequate supply of talented concerned teachers to work in poverty areas. Through the Teacher Corps, these schools can make use of teams of experienced teachers and teaching interns who are well prepared and eager to teach in these deprived areas.

Today, over 1,200 Teacher Corps members are working in local schools. School districts requested more than twice this number. The Corps has been successful in attracting young people into teaching and in bringing former teachers out of retirement. The program has also proved attractive to Peace Corps members returning from their tours of duty. The Teacher Corps has attracted talented people who might not otherwise have joined the teaching profession.

The key to the effectiveness of the Teacher Corps is that it embodies one of our country's most important values: the desire to help other people. The Teacher Corps provides a method for translating such personal idealism into concrete action.

One useful side effect of the Teacher Corps is that it is having a beneficial influence on teacher training practices. The teacher interns are enrolled in college education courses while they are teaching in deprived school districts. Thus they are able to bring their rapidly growing experience into the college classroom. Schools of education are coming to see the advantages in providing trainees with more extensive field experience.

Some critics have charged that the Teacher Corps would lead to Federal control. Others have argued that the objectives of the Corps can be achieved through other existing programs. Some have charged that the program favors large cities and ignores rural areas.

On the question of Federal domination, it is true that the recruitment and training is arranged by the Office of Education, but that is where the Federal initiative stops. After that, the Corps member works in the school district as a local employee. His salary is fixed by the district. Since the local authority hired him, they have the right to fire him. He is subject to all the rules and regulations that apply to his fellow teachers. He receives his special training at a nearby university—another tie to the community. In addition, under a provision in last year's Appropriation Act, part of the cost of the program is borne by the local school district.

As for the charge that the objectives of the Teacher Corps can be met through other programs, I would like to point out that the Corps is the only teacher training program in existence today that is specially tailored to meet the needs of the underprivileged. It does this by making it possible for local school districts to draw upon a national pool of teachers and teaching interns. It would be very difficult for most economically disadvantaged areas to attract the kind of teachers who have joined the Teacher Corps. The Corps offers the flexibility and effectiveness of national recruitment without impairing local autonomy. In addition, one of the best things that these young people bring to their jobs is enthusiasm and high morale, and there's no question that those qualities are heightened and preserved by membership in a nationally known Corps.

Finally, on the question of whether the Teacher Corps assists only large cities, I would like to make it clear that a significant portion of the program is directed toward impoverished rural communities. Of the school districts already involved, over 25 percent are in rural areas.

The large number of membership applications, the significant interest shown by school districts across the country, and the magnitude of the problem of teaching the disadvantaged lead us to propose an expansion of the Teacher Corps, both in 1967 and 1968. I am convinced that this program is worthy of increased support from Congress.

STRENGTHENING STATE ADMINISTRATION

Most of the programs I have mentioned up to now depend heavily on State departments of education. Strengthening of the State administrative and planning structure is crucial to the Federal-State

partnership in education. At present most are not equipped to play their role in the upgrading of the American education system. In addition to funds for State administrative expenses included in the various educational assistance programs, we are requesting funds to support planning, research, statistical analysis, and technical assistance at the State level. These efforts will be expanded and better organized as a result of the new legislation I mentioned earlier to authorize comprehensive State education planning.

HIGHER EDUCATION

Higher education today faces a very difficult future. We need to improve the overall quality of higher education and greatly increase the capacity of the system. These are problems that we must face today. If we neglect them many talented children will have to settle for a second-rate college education, and some may find it hard to gain entry at all.

DEVELOPING INSTITUTIONS

Many colleges in America do not have the resources to provide a high-quality academic program. Typically these are former teachers colleges or underdeveloped southern Negro colleges. These schools are struggling to improve. They are so-called developing institutions. Title III of the Higher Education Act provides a special assistance program to accelerate their development. It encourages these colleges to establish cooperative relationships with each other or with stronger institutions such as universities or private research institutions. It also supports teacher exchanges, fellowships, and sharing of facilities. Continued support for this program is essential to making a high-quality education generally available to the young people of America.

INTERNATIONAL EDUCATION

If the United States is to continue its position of world leadership, we must have the knowledge and trained manpower to work effectively with other countries. The International Education Act of 1966 authorized a program to strengthen the capacity of our schools and colleges to do this job in the Nation's interest.

In order to coordinate our programs in international education, we are establishing a Center for Educational Cooperation in the Office of the Secretary. The Center will administer the new programs established by the International Education Act, as well as previously established programs of the Department dealing with international education. It will serve as a focal point for strengthening the international programs of our own schools and colleges.

The 1968 budget for international education will support university-based centers for international study. Both existing and new centers at the undergraduate and graduate level will be assisted. Colleges and universities may apply for grants to improve curriculum, to enlarge and improve the quality of faculty, and to finance special projects having international significance.

May I say, Mr. Chairman, colleges and universities of this country have done an extraordinary job in the past 20 years without Federal support of sustaining the national interest by working on international

affairs and by preparing their students to live in the kind of world we now live in. But the sheer expense of doing that has grown considerably and they need help to do this job.

We should emphasize, Mr. Chairman, that this assistance will not be confined to language instruction or to studies of a given area of the world. We also plan to support programs that train the university graduate to recognize the international dimensions of their professions. For example, the education afforded a business administration major should not be confined to domestic trade practices. It should also prepare him to operate in the broader field of world commerce. The more the college graduate knows about other parts of the world, the better prepared he will be to pursue his own profession and further the interests of his country.

EXPANDING CAPACITY

To meet the basic need for new and better facilities—classrooms, libraries, and laboratories—we administer both grant and loan programs. In 1968, the grant program will support 1,100 construction projects at universities, public community colleges, and nonprofit technical institutes. The loan program will support 250 additional projects. A new approach to financing this loan program will be taken in 1968. Part of the loan funds will be derived from the participation pool operated by the Federal National Mortgage Association. Under this arrangement, loan notes from the borrowing universities and colleges are placed in a pool, or trust, and shares in this pool are sold on the private capital market. The proceeds of these sales are in turn used to finance new loans. The use of participation sales is a method of stretching the Federal investment in higher education.

TEACHER DEVELOPMENT AND UTILIZATION

The really essential element in the educational system is the teacher. Sophisticated equipment and new buildings are important, but will fail in their purpose if well-trained teachers are not available to use them properly. Congress has authorized a variety of approaches to help schools and colleges attract and train the necessary teachers. One of these is the forgiveness feature of the student loan program whereby teachers can be relieved of paying up to 50 percent of the money they borrow for their college education. Another is the fellowship program for prospective and experienced teachers. In 1968, 4,000 fellowships for elementary and secondary school teachers and 17,000 for future college teachers will be awarded. In addition, the Department also supports short-term training institutes for teachers, supervisors, and counselors. Legislation recommended by the President would consolidate these programs and provide new authority to include school administrators and teacher aids in the training assistance program.

STUDENT ASSISTANCE PROGRAMS

For the Nation's educational system to be effective, it must be accessible to every qualified student. The Department administers a number of loan and grant programs to remove financial barriers to

an education. The 1968 budget request will provide loans for 1.2 million college students and 113,000 vocational students, educational opportunity grants for 285,000 undergraduates, and work-study opportunities for 226,000 college students.

EDUCATIONAL RESEARCH

We as a Nation are currently making a very small investment in educational research. This investment seems even smaller when compared to the large investments made by industry in product research and development—or when compared to the investment made by the Government and the scientific community in research in the biological and physical sciences.

Technology has brought radical changes to almost every field of human endeavor. Advances in communication techniques have been dramatic. Yet, their application to education lags far behind other fields.

We want to make sound decisions about aid to elementary and secondary education. We want to make wise choices about the future of higher education. Mr. Chairman, we cannot hope to do so unless we establish a better funded and better organized research and development effort. It is through such an effort that the educational system may assess its strengths and shortcomings and move on to new solutions. Such an effort will produce information and models to guide school systems and the public in their own steps toward educational improvement.

Recent education legislation, increased Federal resources, and an awakening of industry have provided a new impetus for educational research and development. This program offers incentives to attract the individual researcher into study of the learning and teaching processes. It builds on the traditional concept of university-based research and at the same time provides new mechanisms designed to involve school systems, the community, and other disciplines and interests.

Mr. Chairman, among our many priorities for education I would rank support of educational research at the very top. I believe our goal should be to expand educational research to a point where it compares favorably to that of science and industry. Our 1968 budget of slightly less than $100 million is but a step toward this goal.

THE NATION'S SYSTEM OF HEALTH SERVICES

Let me now turn to our programs in the health field.

We have done very well in advancing medical science, and we intend to continue and broaden our support of biomedical research. But we haven't done well in making the advances available to all Americans. Indeed, a good many are almost untouched by those advances.

We need to train more health manpower; we need to develop new patterns of professional utilization so that we will make the best use of scarce manpower; we need to find new ways to deliver health services—so that we can get health care to the disadvantaged, so that people far from the great medical centers can have the most modern care, so that we make the best use of expensive facilities and equipment.

REGIONAL MEDICAL PROGRAMS

Several recent health measures are directed toward these problems. One of the most innovative is the legislation which authorized regional medical programs for heart disease, cancer, and stroke. Its purpose is to make the most modern techniques in diagnosis and therapy available outside the great medical centers in which they originated. To this end, it seeks to bring together people and organizations who have worked together only sparodically or not at all in the past. These include the practicing physicians, the community hospitals, voluntary agencies, State and local health departments, and university medical centers.

As you look at that list, you might think they have worked together but, in fact, they have not.

The program is still in its early stages. The planning process, which crosses so many traditional lines and which involves the medical resources of an entire region, takes time. The first operational grants were awarded just last month.

Where a great wall once separated the medical school from the practitioners in the community, a constructive dialog has begun. Both the universities and the medical profession are exploring ways of bringing the latest medical knowledge to physicians who have been out of school a long time. Methods of improving the delivery of health services through such means as the adaptation of electronic computers to the practice of medicine are being actively developed.

COMPREHENSIVE HEALTH PLANNING AND SERVICES

Another promising innovation in the health field is the partnership for health legislation, enacted last year by the 89th Congress. It represents a major step to strengthen the Federal-State-local health structure. It will enable States and communities to approach their own health needs more rationally, to set their own priorities, and to devise new patterns for the delivery of health services. It replaces restraint with flexibility and narrowness with comprehensiveness.

As I see it, the key elements of the new approach are:

Comprehensive planning as the foundation for a rational and effective use of all health resources;

Flexibility to put the kinds and amounts of resources where the States and communities think they are most needed;

Development to identify and provide initial support for new approaches to disease control, new sources of health manpower; and

State and local discretion to determine priorities, rather than having to fit within nationally determined areas of emphasis.

HEALTH MANPOWER

While we are moving toward improved systems for the delivery of health services, we are also seeking ways to produce the trained health manpower we so urgently need. An important part of the budget before you will be channeled in this direction.

There are a large number of grant programs aimed at the manpower problem in the various health professions. These programs not only support the training of personnel requiring advanced degrees, but

help to produce more nurses, medical technologists, medical social workers, and related personnel.

They fall into four main categories:

Support for construction of facilities for medical, dental, nursing, and other schools;

Curriculum improvements in these schools;

Student assistance through loans, opportunity grants, and traineeships; and

Studies and demonstrations of ways to make the time of the doctor, the dentist, and the nurse more productive.

All of these efforts will be further strengthened by the 1968 budget. Their focal point is the newly created Bureau of Health Manpower of the Public Health Service.

HEALTH SERVICE FACILITIES

We have, as a nation, for some time recognized a Federal role in assisting in the creation of physical facilities for health care. The Hill-Burton hospital construction program is now in its 21st year. Since its beginning, it has been repeatedly expanded and modified to meet changing needs. We are now furnishing substantial amounts of money, matched by local and private contributions, to the construction of new hospitals, nursing homes, and other extended care facilities, and to the expansion and modernization of existing ones.

Among the more recent additions to our construction assistance programs are two types of facilities for the treatment of the mentally retarded—those which are community centered, and those which are university-affiliated teaching centers. We are also moving forward with the construction and staffing of community mental health centers—a new departure in treatment of the mentally ill which shifts away from reliance on the large and isolated State mental hospital. State plans for community mental health programs are now well advanced. Construction grants for 93 mental health centers have already been awarded. Fifty-four existing centers have received staffing assistance. The benefits of this program are already becoming evident in communities across the country.

HEALTH RESEARCH

Undergirding all our efforts in health is a broad base of biomedical research. Our 1968 request for the research programs of the National Institutes of Health and the National Institute of Mental Health is $1.3 billion—an increase of about 4 percent over last year.

This budget will support about 14,500 separate research projects, conducted mainly by American scientists.

It will help support the training of about 26,000 research workers at various stages in their careers. And it will help increase our knowledge of life and health, from the mechanisms of heredity to the perfection of the artificial heart and the artificial kidney.

We think that this substantial investment in health research is a sound one which must continue.

AREAS OF SPECIAL CONCERN

In summary, then, our efforts to strengthen the national system for health services are directed toward: organization and planning; manpower; facilities; and research.

We also carry the responsibility for dealing with a number of special problems of national significance, such as air pollution, and for providing assistance to special population groups whose needs require attention. Among the latter are the disabled, the aging, and the Nation's children. I would like to highlight these areas briefly.

AIR POLLUTION

I suppose that no one on this committee or anyone else who spends much time in Washington needs to be persuaded of the extent or seriousness of the air pollution problem. The Clean Air Amendments of 1966 make it clear that its solution has a high national priority. Our 1968 budget contemplates making full use of the legislative authority we now have. The budget will permit a general expansion of the air pollution program with particular emphasis on grants to State and local control agencies, enforcement of current Federal standards for motor vehicles, and development of better methods to control automotive emissions and sulfur oxides from fossil fuels.

FOOD AND DRUG CONSUMER PROTECTION

Another priority area is the consumer protection program of the Food and Drug Administration. This agency has an enormous responsibility and a strong mandate from Congress to guard the public against contamination, fraud, impurity, and hazards in the products on which our lives depend. One of its important activities in 1968 will be implementation of the new "truth in packaging" legislation. It also plans to step up its review of new drug applications, to increase the surveillance of drug manufacturers, to intensify the program to control illicit traffic in drugs, and to conduct a long-range study of the safety of oral contraceptives.

PROGRAMS FOR SPECIAL GROUPS

I have already mentioned briefly special programs directed toward treatment of the mentally ill and mentally retarded, as well as education of the handicapped. Our Indian health program is not considered by this subcommittee. There are, however, several other program areas aimed at special groups which seems to me to deserve attention.

VOCATIONAL REHABILITATION

Vocational rehabilitation is a well-established Federal-State program which takes seriously disabled people and gives them whatever is necessary in the way of therapy and training to put them back on the job.

Our budget request for 1968 will enable us to expand this program, to train more people in rehabilitation counseling, occupational and physical therapy, and related disciplines, and to match all available State funds under the authorization for the basic grant program. With this increase, we expect to rehabilitate a record number of

218,500 people next year. Our experience has shown that the people helped under this program repay in taxes alone many times over the money invested in their rehabilitation.

DISADVANTAGED CHILDREN

We estimate that in low-income areas six out of every 10 children with chronic health problems are not receiving any treatment. Infant mortality rates are alarmingly high in these areas. The Social Security Amendments of 1965 authorized grants for comprehensive health care for school and preschool children living in city and rural slums. We hope to expand this program during the coming year to reach about a million and a half children. Under other Children's Bureau programs, 2 million infants will attend well baby clinics and 400,000 mothers will receive prenatal care, including many who risk premature delivery.

The medical assistance program authorized by title XIX of the social security amendments is also helping to meet the medical expenses of needy children and their families. The title XIX program requires the States to draw up comprehensive health plans and to determine which families are eligible for assistance. By July 1, 1967, medical services must include inpatient and outpatient hospital care, caboratory and X-ray services, physicians' services, and nursing home are for those over 21.

By the start of this year, 28 State plans had been approved. We expect that 48 States will be participating by the end of fiscal year 1968. We are requesting legislation to encourage the States to improve their programs and to insure that Federal sharing will be equitable. I think we can expect within a few years to see comprehensive services for all the needy replacing piecemeal program for special groups such as the blind and the aged.

THE AGING

Today, we are beginning to see older people as people—with special needs and problems but with the same aspirations as the rest of us. And we are taking a number of steps to meet them. Medicare and social security are the most prominent programs, and I want to return to those in a moment. But we are also looking broadly at other needs of the aged—housing, recreation, opportunity to work and to learn, and their need to participate in the life of society.

Through the Administration on Aging, grants are available to the States to support a variety of community services for older people. To be eligible for these grants, State agencies must come up with a comprehensive plan to meet the needs of their older citizens. Forty-four State plans have been approved thus far. We expect that all 55 eligible jurisdictions will be operating under approved plans by the end of 1968.

SOCIAL INSURANCE AND INCOME MAINTENANCE

As you know, we are responsible for two types of programs to help Americans maintain a decent standard of living—social insurance and welfare programs of income maintenance.

MEDICARE

One of the most significant developments in our three decades of social security took effect last year when 19 million older people became eligible for medicare benefits. The preparation for this program was a huge administrative job. Many people feared that hospitals would be swamped with patients and paperwork. But the fears proved to be groundless, thanks to extensive preparation and the active cooperation of hospitals, doctors, insurance carriers, and State agencies and responsible use of these benefits by older people themselves.

Some 6,700 hospitals—including 98 percent of the Nation's hospital beds—are participating in the program. Medicare is helping to upgrade the quality of care in these hospitals, not only for older people but for everyone.

Extended care benefits went into effect on January 1, again with dispatch and efficiency. Some 3,500 extended care facilities have been certified to participate in medicare.

More than 2.6 million older Americans have had their hospital bills paid by medicare. Over 90 percent have chosen supplementary medical insurance and between 4 and 5 million have received physicians' services.

SOCIAL SECURITY

The social security program is our basic method for replacing the income a worker or his family loses when he retires, becomes disabled, or dies. Twenty three million Americans rely on it for their major source of support. Yet under the present benefit levels, more than 5 million aged beneficiaries still live in poverty. A substantial increase is essential.

We are proposing an increase of at least 15 percent for all persons, with an increase of the minimum benefit from $44 to $70. Other improvements are also being requested. These increases would be financed by raising both the social security tax rate and the earnings base.

PUBLIC ASSISTANCE

While social security benefits are based on earnings, public assistance is provided on the basis of current income. The Federal Government matches State and local contributions.

There are four categories of public assistance: old age assistance, aid to the blind, aid to the permanently and totally disabled, and aid to dependent children. Although aid to families with dependent children is the best known of these programs, it will account for less than half of the cash payments estimated for 1968. Until 1967, in fact, more money was spent for old age assistance.

The total Federal contribution for public assistance will increase in 1968. Within the total, however, there will be a continuing shift in balance. As social security is broadened, fewer people will need old age assistance. Aid to the blind is also decreasing because blindness today is less prevalent. On the other hand, more people will receive assistance under the programs of aid to the disabled and to families with dependent children. This is due partly to population growth, partly to the fact that the States are adopting more liberal eligibility

standards, and partly to a marked increase in the number of AFDC cases. This means that more people who need assistance will get it.

The average monthly payment for each person who receives aid to families with dependent children will be about $36. A family of four would receive about $1,700 over the course of the year. This is little more than half the generally accepted poverty level of $3,000 a year. Seen in this light, welfare payments are hardly extravagant.

Mr. Chairman, in this statement I have just touched on the highlights of the Department's major programs.

In closing, gentelmen, may I make a few observations about the new relationship between HEW and this committee which begins here today?

Many of you are new to this committee and I am sure will be taking a fresh look at the Department of Health, Education, and Welfare. No doubt you will be examining its programs and even its basic purpose from a different perspective and at a closer range. I am confident that your participation in the affairs of HEW will bring new influences and an infusion of new ideas into our programs and our operations.

Since I, too, am still new to the Department—at least realtively so—I see this as an excellent opportunity to work together to make the Department a more efficient and effective instrument for the American people.

I shall be glad to answer any questions you may have.

Organization of Department

I have a chart which you may wish me to talk to at some point for those members who are not fully familiar with this Department.

Mr. Flood. I would suggest you do that now.

Secretary Gardner. Let me start with this line outlined in red because this is the heart of the Department. It indicates the operating agencies of the Department. The general view is that I have three agencies; I actually have eight agencies.

SOCIAL SECURITY ADMINISTRATION

By far the largest is the Social Security Administration with about 50,000 employees, and it manages not only the regular social security program but the whole medicare program, and I would say that upon the whole it is the best managed department that I have. It is just extraordinarily good. Robert Ball is the Commissioner and he is great.

PUBLIC HEALTH SERVICE

Second, Public Health Service, under the Surgeon General William Stewart has a very broad mandate for all aspects of health. It has within it the National Institutes of Health, which carries on a very large research program; the Communicable Disease Center in Atlanta, which is a very modern scientific establishment for monitoring the occurrence and prevention of contagious diseases. The Public Health Service handles all of the hospital programs and health manpower programs, and so forth.

Both of these major agencies have gone through a major reorganization in the past year; social security primarily because of medicare,

but the Public Health Service we just took apart and put together again in a different pattern because it had been going on for many years without reorganization and it seemed that its modern functions just did not fit the old style organization.

OFFICE OF EDUCATION

The Office of Education is a very much smaller unit in terms of people, but it spends a respectable amount of money. It puts out about $4 billion a year now and most of you are fairly familiar with that.

WELFARE ADMINISTRATION

The Welfare Administration we have just talked about in connection with the public assistance grants and it is also a small administration that spends a lot of money. Neither of these have very large staffs. Social Security has a very large staff, so does the Public Health Service.

Those are the four giants in my Department. They are very large spenders.

FOOD AND DRUG ADMINISTRATION

The Food and Drug Administration is not very large, but you hear quite a bit about it. It manages to live a fairly lively existence and it is our one regulatory agency and it, too, has been completely reorganized. In fact, every agency I have talked about except Welfare has been completely reorganized in the past year. The Food and Drug Administration very badly needed such reorganization at the time Dr. Goddard came in.

VOCATIONAL REHABILITATION ADMINISTRATION

Vocational Rehabilitation is a very small agency. It handles the vocational program which I just described to you. It is a very successful program and a very successful agency under Mary Switzer, whom many of you know.

The Administration on Aging again is very small, brandnew, created last year, and it has the curious characteristic that it has a very general responsibility for programs on the aging, particularly new kinds of programs to work with the aged, but it is within a department where very large concerns for the aging are lodged in other agencies. Social security is a program for the aged. The Public Health Service does substantial research work on aged people. The Welfare Administration has programs for the aged. So the Administration on Aging has a responsibility and a concern that extends far beyond its own boundaries. It not only manages a rather modest grant program which you provided, but it is concerned with keeping an eye on all of the things that are going on and seeing where the next advances ought to come in working with the aged.

ST. ELIZABETHS HOSPITAL

St. Elizabeths Hospital is an anomaly on the chart. I have been trying ever since I got here to get it off the chart and it is no easy task, let me tell you.

We have been negotiating with the District to give it to them, but there are enormous problems of doing so.

The District's Health Commissioner wants it very badly. Some people in the Budget Bureau feel very strongly it should go to the District, but apparently the bureaucratic complexities of getting that done are just enormous. If we do not turn it over to the District, we will almost certainly put it under the National Institute of Mental Health in the Public Health Service. In other words, it does not really belong on this chart as a separate body; it never did.

The heads of these operating agencies report directly to Wilbur Cohen and myself. I think you have all met Wilbur Cohen. He and I work very closely together. We do not have separate duties, we share duties and each knows what the other is doing and any operating head can come directly to us. There is no layering at all.

Now, the key question in a department of this size is how you pull it all together, because no modern problem stays in a box or an organization chart.

I just talked to you about aging, but exactly the same thing is true of education. Some of the most interesting things being done in welfare today are educational in nature. The Social Security Administration, when it got into medicare, got into the health field in a big way. Welfare is administering title XIX which is also a health program. Vocational Rehabilitation has health aspects. So the question is, how do you pull this together to get the job done and to get the most for the taxpayers' dollars.

I consider that my No. 1 job is management. There just is no question that the chief responsibility I have to you and the American people is to try to make these programs work effectively and efficiently.

Let me describe the level of the Assistant Secretaries. The purpose of this level is to accomplish the kind of pulling together that I have just talked about.

GENERAL COUNSEL

First we have some very familiar and well-known staff functions. The General Counsel is characteristic. He functions for all of the Department, works with all units of the Department on the legal aspects of our activities.

ASSISTANT SECRETARY FOR ADMINISTRATION

The Assistant Secretary for Administration is again a very familiar function. He works with all of these people on administrative matters and personnel and so forth. The Comptroller is in charge of the budget which is typically a very powerful instrument for getting hold of an organization, and we use it as such. It is a means of casting a net over the entire organization and its objectives and having some review of those objectives at the top because every dollar they spend has to be reviewed by us.

Again, every legislative proposal that they submit has to be reviewed by us, and again it is an opportunity to pull this together and maintain some kind of internal discipline and order.

ASSISTANT SECRETARY FOR PROGRAM COORDINATION

Then a less familiar function. The Assistant Secretary for Program Coordination has the new PPBS system under his charge, the new planning, programing and budgeting system. He is carrying out for our Department the kinds of analysis, cost-benefit studies, and comparable evaluative efforts that will permit us to judge what we are doing.

As you know, this program budgeting approach cuts across departments, cuts across agencies. When he is looking at something such as human investment, he is not asking what box it is in on the chart. If you are asking yourself how you can make people more employable, he may be looking at vocational rehabilitation, he may be looking at the Office of Education, and he may be looking at some aspects of the Public Health Service.

If he is considering investments in children, for example, he may be dealing with the Public Health Service, he may be dealing with the Welfare Administration which has the Children's Bureau. But the question is, What are our goals with respect to this particular function, how do we think we get to those goals, what is the relative cost of going down different paths toward these goals? These are the cost-benefit analyses, some of which I am sure you have seen.

The next three are really quite different than the others. These are substantive Assistant Secretaries. They each have a field, they have a functional field.

ASSISTANT SECRETARY FOR HEALTH

Let's start with health. The Assistant Secretary for Health works on any health matter that cuts across boundaries, either within the Department or outside the Department. A good example within the Department is the collaboration between Public Health Service and Social Security on medicare. The Assistant Secretary was very deeply involved in that collaboration in making it work, and it worked very, very well, just almost perfect.

The Public Health Service and the Welfare Administration had to work together on title XIX. Again, he was heavily involved. It did not work so well. It took a lot of pushing and a lot of negotiation and a lot of debate to see how we could make these two work together, and they have finally worked together fine.

Take another thing such as pesticides. The Public Health Service, but also Agriculture, and to some extent the Food and Drug Administration, get involved with pesticides. The whole problem can only be dealt with by someone who is above these coordinate agencies and can get them together and get them to sit down in the same room. He has a few other special responsibilities such as alcoholism and population planning and so forth, but that is his main function.

ASSISTANT SECRETARY FOR EDUCATION

The Assistant Secretary for Education. Wherever an educational problem cuts across agency lines, he is involved. Wherever education cuts across our Department and another department, he is involved. He is the Chairman of the Federal Inter-Agency Council on Education, which I would not say is the most effective body in the world, but

it has a possibility of becoming more effective. I think that Paul Miller, who is an extremely able man, will get the most out of it.

But questions such as manpower, which cut across our Department and the Office of Economic Opportunity and the Labor Department, come to him and they are very difficult.

ASSISTANT SECRETARY FOR INDIVIDUAL AND FAMILY SERVICES

The Assistant Secretary for Individual and Family Services is concerned with the kinds of things that are involved in social services, welfare, public assistance, and social programs affecting families children and individuals. It happens we have in this position Lyle Carter, who came over from the Office of Economic Opportunity and is very familiar with the problems of the cities. So we have had him serving as our main point of contact with HUD and he has done that very well.

REGIONAL OFFICES

I will say two or three more words.

First, regional offices. When I came in the regional offices had not, or at least felt they had not received as much attention from the Secretary as they might. I suppose regional offices always feel that way; but there was some reason to believe they had not played a very significant role in the organization. I have done everything possible to strengthen our regional offices. The more we look at the job of putting together these Federal programs out in the cities and out where they have their impact on the community, the more apparent it is that you can only do that kind of coordination locally. You can only put these things together in terms of local leadership and local negotiation and to meet local problems. Our regional people have to be able to serve the mayors and the Governors with the kind of information they need and the kind of decisions they need. We work very, very hard at that.

I think that is about all that I need to say at this time.

Mr. FLOOD. Mr. Kelly, I think you have some charts you want to talk about; do you not?

GENERAL OPERATION OF THE DEPARTMENT

Mr. KELLY. Yes; I do. If I may, before getting to that, I would like to show you a few charts which outline how the Department operates to meet the various problems the Secretary spoke about. Our programs carry out mutual objectives and use mutual mechanisms for carrying them out. We thought that it might place our operations somewhat in context if we were to look at the Department in general terms before starting into individual programs.

(The charts referred to follow:)

HEW PROGRAMS ARE DESIGNED TO—

Strengthen the national system for health care and services;
Strengthen the national educational system;
Maintain income and finance purchase of health services;
Protect individuals from certain hazards of the environment;
Expand and disseminate knowledge; and
Strengthen services for the handicapped, the aging, children, and other selected groups.

In Partnership With—
States and localities:
Health agencies,
Education agencies,
Welfare agencies,
Vocational rehabilitation agencies,
Special State or local organizations;
Colleges and universities; and
Private health sector.
Strengthening the National System for Health Care and Services:
Health manpower—Education and utilization;
Hospitals and health education facilities;
Partnership for health;
Regional medical programs;
Nurse training; and
Community health programs—Mental health and mental retardation.
Strengthening the National Educational System:
Elementary and secondary;
Teacher Corps;
Vocational education;
Library services and facilities;
Student assistance—Loans, work-study, opportunity grants;
Graduate and undergraduate facilities; and
Teacher training.
Maintaining Income and Financing Purchase of Health Services:
Social security benefits;
Medicare/Medicaid;
Aid to the aged, blind, and disabled; and
Aid to families with dependent children.
Protecting Individuals From Certain Hazards of the Environment:
Food and drug consumer protection;
Air pollution control;
Communicable disease control;
Solid waste disposal; and
Occupational health.
Expansion and Dissemination of Knowledge:
National Institutes of Health;
Educational research;
Communicable Disease Center;
Cooperative research in social welfare;
National Library of Medicine;
National Center for Health Statistics; and
Research facilities construction.
Strengthening Services for Special Groups:
Indian health;
Crippled children;
Vocational rehabilitation of the disabled;
Education of the blind, deaf, and mentally retarded; and
Services for the aging.
Direct Operations:
Operation of health facilities:
Public Health Service hospitals,
Indian hospitals, and
Saint Elizabeth's Hospital;
Collection and dissemination of statistics;
Medical research;
Operation of social security system; and
Administration of grant programs.

Mr. Kelly. The HEW programs are designed to strengthen the national system for health care and services, to strengthen the national educational system, to maintain the income and the individual's ability to purchase health services, to protect individuals from certain hazards of the environment, to expand and disseminate knowledge, to strengthen services for the handicapped, the aging, children and certain other selected groups such as Indians.

It does this in partnership with States and localities through their health agencies, their education agencies, their welfare agencies, their vocational rehabilitation agencies, and certain other special State and local agencies such as their aging coordination machinery.

The Department does this in partnership with colleges and universities and it does it through strenthening the private health sector such as the Secretary indicated is occurring in the medicare program.

HEALTH CARE AND SERVICES

This strengthening of the national system for health care and services is being brought about by support for the expansion of health manpower, for the expansion of health educational programs, and for studies that deal with the utilization of scarce manpower. We are strengthening health care and services by assisting in construction of hospitals and health education facilities; we are doing this through the partnership for health program that the Secretary covered in his opening statement as the new approach to State and local problems in health. We are doing this through regional medical programs, through expansion of nurse training and bringing nurses back into the field for retraining. And we are doing this through community health programs, such as the expanded program for community mental health and the program for mental retardation.

EDUCATION

The strengthening of the national education system is being brought about through the major new program of elementary and secondary education support, through the Teacher Corps, through our programs of vocational education, through the expanded programs of library services and facilities, through the system of student assistance which is a composite of loans and of work-study programs and of opportunity grants, and through assistance for the construction of educational facilities both for graduate and undergraduate purposes, and through the major effort to increase the supply and the quality of teachers.

INCOME MAINTENANCE

We are maintaining income and financing the purchase of health services through the benefits of the social security program, through both medicare and medicaid, through aid to the aged, blind, and disabled under public assistance, and through aid to families with dependent children under public assistance.

PROTECTION FROM ENVIRONMENTAL HAZARDS

We are protecting individuals from certain hazards of the environment through the Food and Drug Administration which is concerned with drugs, food, and cosmetics, through the air pollution control program, through the communicable disease control program, through the solid waste disposal program, and through our programs of occupational health.

RESEARCH

We are engaged in the expansion and dissemination of knowledge through the major research efforts conducted and supported by the

National Institutes of Health, through the newly developed educational research program, through the research activities of our Communicable Disease Center, through the cooperative research program in social welfare, through the National Library of Medicine, through the National Center for Health Statistics, and through assistance for the construction of research facilities.

SERVICES FOR SPECIAL GROUPS

We are providing strenghthened services for special groups through our Indian health program, through the program that purchases services for crippled children, through the vocational rehabilitation program that aids the disabled to return to the labor market, and through the educational programs that are concerned with the blind and the deaf and mentally retarded, and through the services that are provided for the aged.

And in addition to the basic programs that provide grants or payments to individuals, we do perform certain direct services. We operate health facilities. We have about 12 Public Health Service hospitals, we have Indian hospitals on reservations, all of the Federal reservations in this country, and in Alaska; we operate St. Elizabeths Hospital here in the District of Columbia. We collect and disseminate statistics concerned with health, education, and welfare. We conduct some medical research directly. The social security system has offices in 640 locations throughout the country. And we must also administer the grant programs themselves.

The purpose of this, Mr. Chairman, is to just identify that there is a common thread and a common pattern running through the administration of this group of programs.

President's Program To Combat Inflation

I also want to talk to you about the President's program to combat inflation and how we went about it because it does have a major impact on the funds which you appropriated last year and how we are administering them. It also has an effect on the 1968 budget that is before you because the 1968 budget is a continuation of the programs from the base established in 1967.

(The charts used during this portion of the testimony follow:)

President's Program To Combat Inflation (Principles Followed):
- Identification of areas having inflationary impact.
  - Construction starts.
  - Procurement.
- Emphasis on deferral and slowdown rather than curtailment of programs.
- Policies on reduction and deferral applied uniformly to all programs.
- No distinction between recommended and enacted appropriations.
- Searched out changes in budget requirements after budget was submitted, e.g., continuation costs of project grants.
- Applied saving from management improvements.

Actions Are of Three Kinds:
- I. Actions designed to reduce inflation.
- II. Steps to restrict the use of appropriated funds.
- III. Identification of savings resulting from improved operations.

Actions Have an Impact on—
- I. Program Level—Reduction by deferral, stretchout, or cutback of level of effort.
- II. Obligations—Reduction in 1967 commitments to spend.
- III. Expenditures—Reduction in 1967 payments from the Treasury.

KINDS OF ACTION TAKEN

Reductions

[In millions of dollars]

	Program level	Obligations	Expenditures
I. Actions designed to reduce inflation:			
Construction slowdown	$349.5	$151.5	$176.7
Deferral of purchases—supplies, equipment, etc.	12.6	0	3.0
Deferral of project grants	83.9	17.5	56.7
Total actions designed to reduce inflation	446.0	169.0	236.4
II. Steps to restrict the use of appropriated funds—the original requirements for which have changed since the original budget was presented to Congress:			
Limitations on use of grant funds for continuing projects budgeted in excess of actual needs	9.9	9.9	6.7
Prohibition against the use of funds appropriated for specific programs where planning, recruitment, or other conditions precedent have not materialized	45.9	45.9	24.0
Limitation on the reallocation of unused formula grants and loans	82.6	82.6	49.0
Total steps to restrict the use of appropriated funds	138.4	138.4	79.7
III. Identification of savings resulting from improved operations:			
Savings from management improvements	2.0	2.0	1.5
Restriction on administrative expenses—travel, supplies and equipment purchases and reproduction	3.7	3.7	2.7
Total savings resulting from improved operations	5.7	5.7	4.2
Grand total	590.1	313.1	320.3

PRESIDENT'S PROGRAM TO COMBAT INFLATION (BY AGENCY)

[In millions of dollars]

	Program level	Obligations	Expenditures
Food and Drug Administration	$1.2	$0	$2.1
Office of Education	327.7	228.9	182.2
Vocational Rehabilitation Administration	3.3	1.3	2.0
Public Health Service	244.6	74.6	123.9
Saint Elizabeths Hospital	.7	0	.9
Social Security Administration		0	3.3
Welfare Administration	11.9	7.7	4.6
Administration on Aging	.6	.6	.4
Howard University		0	.9
Office of the Secretary	.1	0	(1)
Total	590.1	313.1	320.3

[1] Less than $50,000.

Mr. KELLY. We approached the problem like this. First we endeavored to identify the areas in which the kinds of activities we engaged in had a potentially serious inflationary impact during a period in which the economy was being heated up. We identified the two principal areas where this occurred in HEW: construction programs and procurement. Almost $5 billion worth of construction programs are influenced by HEW, because we make loans and grants paying part of the cost, our part being somewhere in the neighborhood of about $1.6 billion. We have an inflationary impact through procurement of equipment, supplies and materials because the point of the order tends to be the point on which the national economy feels impact of large scale Federal expenditures.

We placed our emphasis on deferral and slowdown, rather than the curtailment of programs. We endeavored to get the effect of reduction by deferral and stretchout or cutback. We felt the programs we had presented to you were meritorious and desirable and we endeavored to achieve our purposes despite deferral and slowdown.

We endeavored to apply policies on reduction and deferral uniformly throughout the entire Department. We did not make any distinction among programs and we did not make any distinction based on whether or not the program had been requested in the budget or whether or not the activity had been decreased or increased as a result of the congressional review and action on the budget and legislative program.

We searched out change in budget requirements after the budget was submitted. For example, we had identified in the budget for you the cost of continuation of research projects that were being supported. We found that in some of the appropriations we had overestimated that cost. Normally we would have allowed that overestimate to be used to support new projects. This year we did not. We said that where we had an overestimate of that kind occurring that we would impound those funds and not let them be reprogramed to another purpose. Then we also applied all of the savings that had been identified in various management improvement projects as a part of this program.

ACTIONS TAKEN TO REDUCE INFLATION

The actions we took were of three kinds:

First, the major actions designed to reduce inflation; second, the actions we took to restrict the use of proposed funds such as the continuation grant example that I used; and third, to identify the savings which resulted from improved operations.

Now these actions have effects in three ways, and so I have endeavored to define the terms.

PROGRAM REDUCTION THROUGH DEFERRAL

One is program level; that is, the reduction by deferral or stretchout or cutback of the level of effort. An example of this would be that you might approve a project and obligate the funds for construction and proceed with the planning and the design, but if you did not allow the start of that construction to occur, it would not affect obligations, but it would ultimately affect expenditures. We have treated as the program level of reduction the amount, the value of the projects which we have held off of the market for a period of time. Obligations of course are where we have reduced the 1967 level of commitments to make expenditures, and you may recall, Mr. Chairman, there are certain items on which you observed that we were carrying over unobligated balances. It was occasioned by this activity.

Then third, reduction in expenditures is the reduction in the actual disbursements from the Treasury as a result of this activity.

As a result of actions designed to reduce inflation we brought about a reduction of $446 million in the program level which produced a $169 million reduction in obligations and a $236 million reduction in expenditures, or actual disbursements. The largest portion of this

was the result of the construction slowdown which accounts for $350 million in program level and $176 million in expenditures.

If I may when I finish, I would like to give you an example of how we did this and where we stand with respect to it.

The second was that we deferred the purchases of supplies and equipment. We issued orders throughout the Department that the preponderance of procurement should be deferred from the first part of the fiscal year to the last part of the fiscal year in order to avoid having large-scale orders go on the market during that particularly critical time. As a result we took off the market $12. 6 million worth of procurement orders which we subsequently placed but, we moved $3 million of the expenditures into the subsequent year.

And then we had a program of deferring the starting date of new project grants. We moved the starting date of new project grants from the first part of the fiscal year to the latter part of the fiscal year. About $84 million worth of project grants were deferred until the latter part of the year and this had the effect of moving the disbursement of $57 million over into the subsequent fiscal period.

REDUCING EXPENDITURES OF APPROPRIATED FUNDS

The second thing involved steps we took to restrict the expenditure of appropriated funds where the original requirement had changed since the budget was originally presented to the Congress. We limited the use of grant funds for continuation projects where the budget was in excess of needs, and this accounts for about $10 million in activity.

We also restricted the use of funds appropriated for specific purposes where the planning, recruitment, or other conditions did not materialize to the extent that it had originally been expected and we placed these funds under an impoundment. This accounted for about $46 million.

Then we took other actions in places where we had administrative discretion. We placed a limitation on the reallocation of formula grants among the States and this accounted for about $82 million.

We recently reviewed the effect of this policy. When it was applied to all of the programs except elementary and secondary education it only related to redistribution from one State to another, where one State was not going to use all of the resources and we would reallocate it to another State.

In the case of elementary and secondary education, the prohibition against reallocation had the effect of keeping the State from being able to make resdistribution between counties and school districts within the State.

The change in the law on the method of computing the entitlement of each county and each school district had a substantial effect on the amount that they got last year and the amount they got this year. And it was found that if we relieved them and allowed the reallocation in elementary and secondary education to proceed, that it would relieve many of the problems in that program. And on Friday the President approved removing that item from this program of cutback. Therefore the amount of savings in this area will not be as great as they are shown on the chart.

SAVINGS THROUGH IMPROVED MANAGEMENT

The third item consists of savings that have resulted from improved management and operation. We normally identify specific management improvements throughout the Department and include them in our regular report. This year we have required that the amount of money asked be actually impounded and not used, where, under normal circumstances, it might have been reprogramed to some other purpose.

We placed restrictions on administrative expenses. We held back certain of the funds that had been budgeted and appropriated for travel, supplies, equipment, and printing. We saved $3.7 million as a result of this action.

In terms of operating agencies, we have a chart here which shows you the impact that it has on each of the Department's agencies when you apply these policies to their programs.

DEFERRAL OF CONSTRUCTION PROGRAM

I thought you might be interested in what we have done. I will not take you through all the charts, but I think there is one that is particularly interesting.

We first became concerned with the inflationary impact of the construction program throughout the Department last April 1. We asked the operating agencies to give us a schedule of how rapidly these projects would be started in construction, and we graphed this for all of the programs that are involved in loans and construction grants. And then we endeavored to smooth out that curve and to purposefully slow down the program. We have kept track of what we have done each week since we started the program and we have actually slowed it down to a greater degree than we predicted we would. We make each project come through the headquarters office and be cleared for advertising of bids. We are giving priority to those in which the building has to be ready in order to start a school year. We are also giving priority to hospital construction.

But the interesting thing, it seemed to me, on the anti-inflationary aspect, was when we plotted the predictions by week from the operating agencies, that we got these huge peaks and valleys and would put this tremendous amount of work on the market at one time. Our objective was to establish a relatively level amount of work that would go on the market at one time. And the red actual figure shows we have substantially done that.

We fell below our level because of the weather conditions at this point in time and now are beginning to come back. This is the reason why we were able to make such a large scale program level reduction, as I showed on the earlier charts.

Thank you, Mr. Chairman.

Mr. FLOOD. Mr. Kelly, how long have you been Comptroller?

Mr. KELLY. I actually came with the Department of Health, Education, and Welfare as their budget officer in 1954 and the position was elevated to the comptrollership about 1961. At that time, I was designated Deputy Assistant Secretary for Administration. Secretary Gardner elevated the comptrollership. I now serve as an Assistant Secretary.

Mr. FLOOD. How did you get here? Where did you go to school?

Mr. KELLY. I graduated from Columbia Business University Law School here in town. I studied both law and accounting, but I started with the Government when I was 18 years old as a grade 1 clerk.

Mr. FLOOD. Where were you born?

Mr. KELLY. I was born in Washington and grew up in Baltimore.

Mr. FLOOD. A real professional, Mr. Secretary.

Secretary GARDNER. He is terrific, he really is. Just extraordinary.

Mr. FLOOD. Some of these questions, Mr. Secretary, I suppose Mr. Kelly will answer.

How long have you been Secretary?

Secretary GARDNER. Twenty months and about 6 hours. Almost exactly 20 months.

Mr. FLOOD. A little longer than some of the members have been on this subcommittee, as you mentioned in the last paragraph of your statement. I thought that was a very perceptive paragraph, that last one. Indeed your entire statement makes extremely interesting and informative reading.

READER'S DIGEST ARTICLE ON RESEARCH

You made a point in your statement about the importance of research. You are undoubtedly acquainted with the article in the March Reader's Digest entitled "The Great Research Boondoggle." A couple of sentences in this indicate the tenor:

> What we have is quite literally a federal research craze, and it has mounted to absurd proportions.

Second quotation:

> Inevitably this unchecked proliferation has brought on vast boondoggles and also a regrettable waste of scientific manpower.

By the way, your Department got a little special attention in that article.

Secretary GARDNER. Did it? I did not read the article.

Mr. FLOOD. In that case, I will read those excerpts again and you can base your comments on them:

> What we have is quite literally a federal research craze. It has mounted to absurd proportions. Inevitably this unchecked proliferation has brought on vast boondoggles and also a regrettable waste of scientific manpower.

Do you want to say something?

Secretary GARDNER. Yes; I would like very much to.

Mr. FLOOD. Don't forget, I come primarily from Defense and I know something about research.

Secretary GARDNER. I spent 20 years as a consultant of the Defense Department on research matters.

Mr. FLOOD. Yes; I know.

Secretary GARDNER. And have been involved in research practically all my adult life and no one is more keenly aware than I am that you can waste money in research; that you can make a fetish of research; and that some things that go on today are hard to defend.

Mr. FLOOD. Fetish is very good. That is more apt than boondoggling.

Secretary GARDNER. At the same time there isn't any question that the span of activity running from the idea to its application, from the discovery of knowledge to its final use——

Mr. FLOOD. This recalls the old problem of NIH. When do you leave the laboratory and go to the bedside?

Secretary GARDNER. Our whole thrust is to go to the bedside at the moment. We want to keep this strong and effective research program of NIH in the basic biomedical fields; but the way you deliver better medical services is the main thrust in this year's effort. This is true in education, too.

Mr. FLOOD. You also stress research in education?

Secretary GARDNER. Yes.

Mr. FLOOD. Are you an educator?

Secretary GARDNER. I am a psychologist by profession.

Mr. FLOOD. How do you distinguish a psychologist from a psychiatrist?

Secretary GARDNER. A psychiatrist is an M.D. who has specialized in the pathology of human behavior.

Mr. FLOOD. What do you do?

Secretary GARDNER. I have not done this for many years. I left the field of psychology when I went in World War II, but I was teaching and doing research on human behavior, that was my field.

Mr. FLOOD. Basically human behavior?

Secretary GARDNER. That is right.

Mr. FLOOD. Go ahead.

Secretary GARDNER. The American people want so much education, so much in health services, so much in all the other kinds of benefits they can obtain——

Mr. FLOOD. How do you know? Were you ever back on Main Street?

Secretary GARDNER. Oh, yes. I have been in and out of schools all my adult life.

Mr. FLOOD. I know you have been in schools but have you been out of them very much?

Secretary GARDNER. I would imagine my experience in American life is as broad or broader than anybody around this table. I have been a member of corporate boards, have served in the Defense Department in a variety of capacities, I have been a foundation president, I have been a professor, I have gotten into just about every aspect of American life.

Mr. FLOOD. Did you ever belong to the Kiwanis Club?

Secretary GARDNER. I have not belonged to a Kiwanis Club.

Mr. FLOOD. Go ahead. We are back on research.

Secretary GARDNER. Yes. I think it would be very hard to argue that the aspirations of the American people for the benefits of education and health are anything but high. They want as much of health services as they can get and they want as much of education as they can get. It will not be possible to meet all of those aspirations with present methods of doing things. We will not have the money and we will not have the manpower. We are living far beyond our manpower resources today.

Mr. FLOOD. On that point, are you wasting what little scientific manpower we have by locking them up in the laboratories some place?

Secretary GARDNER. The main thing we have to do is find new ways of utilizing professional manpower. It is very difficult. We are trying now to evaluate the effectiveness of research but it is hard to say you are wasting somebody by locking them up in the laboratory. Two fellows at NIH, when they discovered a vaccine for rubella, unlocked enormous possibilities for saving children and sparing people. The social cost of looking after the casualties from this is enormous. Every single home for the mentally deficient in the country has its rubella children. Every home for the deaf and for the blind has its rubella children.

Mr. FLOOD. What is that, for the record?

Secretary GARDNER. Youngsters whose mothers were stricken with rubella during pregnancy.

Mr. FLOOD. German measles.

Secretary GARDNER. Yes, and they have produced children blind or deaf or mentally retarded or a combination of these. Two young fellows working in the laboratory out at NIH discovered a way to cut through that and there will be no more of that kind of children. So the payoff is enormous. You have to have a lot of things going before one of these projects comes through with a big win like that. It may be that 50 percent of our projects will not pay off big but you do not know which of the 50 percent will.

Mr. FLOOD. It is like the daily double, I suppose?

Secretary GARDNER. That is what research is. But we will not be able to do the job in health or in education with the present patterns of utilization of manpower and facilities. We cannot afford the expensive ways of doing it that we have followed to date. For example, if you were educating a small percentage of your youngsters in colleges you could have a marvelous campus with marvelous buildings and dormitories for everybody and a lot of overhead. When you are trying to educate a tremendous portion of your young people in colleges, you have to have urban universities where they can take the streetcar or live right across the street. In other words, this is why we are pursuing the possibilities of television, the possibilities of computerized education, the possibilities of enabling the master teacher to reach more youngsters and be served by teacher aids, and so forth.

Mr. FLOOD. The master teacher? What is that?

Secretary GARDNER. You see, one of the problems in education today is that in most places you go in as a teacher and after you have been there for 40 years you are still at the same rank and the youngster who comes in is at the same rank you are. It is possible we could have a system whereby the senior teachers could have assistants who could correct the papers. This has been tried and it works. We have first-class teachers spending time putting children's rubbers on and doing all kinds of unnecessary things around the classroom that a high school girl could do.

Mr. FLOOD. A real top grade Teacher Corps?

Secretary GARDNER. Yes.

Mr. FLOOD. I do not want to belabor this, but that was quite an article in Reader's Digest, and coming with my Defense background I read it very thoroughly, as you can understand. I wish, if you feel you should, you might add your comments to the record at this point after you do read it.

Secretary GARDNER. I shall be very glad to.

(The following was submitted for the record:)

The article by Mr. Shulz points to several areas of concern to the Department of Health, Education, and Welfare: the appropriate allocation of professional manpower between research and the practice of a profession such as teaching or providing health services; assuring that research projects supported by Federal funds have a valid public interest; and securing a wider distribution of research projects among qualified colleges and universities, both large and small.

We have a number of review, evaluation, and approval steps built into each research program to try to achieve our objectives, and we are constantly concerned with strengthening these operations.

The quality of scientific research supported through Federal programs and the effectiveness and efficiency of program administration have been the subject of numerous examinations. Within the past ten years, for example, the programs of the National Institutes of Health have been the subject of five major reviews and evaluations—one such study every two years. While such studies have provided constructive recommendations for improvements in administration, the overall scientific quality and merit of NIH programs have been consistently judged of the highest excellence.

A searching examination of NIH was carried out two years ago by a committee of distinguished scientists, industrialists, educators, and men of public affairs, chaired by Dean Wooldridge, a scientist-engineer of national distinction.

After an exhaustive analysis, the judgment of the Wooldridge Committee on the quality of the science being supported through NIH programs was stated as follows:

"*Quality of current work.*—The opinion of the Committee, based on the extensive investigations of its consultants, is that the large majority of the intramural and extramural research supported by NIH is of high quality. Out of the 240 "traditional" extramural research grants investigated, the panel teams expressed serious reservation about 9 projects and adjudged an additional 7 to be unworthy of support. In scientific research, such a ratio of ill-advised projects, when judged after the fact, is impressively low. Much more frequently, NIH-supported work was found to set the national or international standard of excellence in its field."

The conclusion of the Wooldridge Committee on the value of the NIH scientific program to the Nation was stated as follows:

"In brief, we consider the NIH program to be sound and recommend its continued support. Its one billion dollar budget is not high, when compared to the more than thirty billion dollars a year the American public pays for assorted health services; the money is on the whole being competently and efficiently employed on a broad spectrum of health-related research; lessons from the past history of science, supported by the current acceleration of medical discovery, strongly suggest a satisfactory future pay-off. Furthermore, as discoveries are made in the life sciences and the physical sciences, new opportunities will be created for health research, and these too should be exploited with the enthusiasm and vigor which has distinguished the NIH program during the past decade. We feel that the Congress in particular deserves considerable credit for its past and continuing support of this kind of farsighted program. We suspect that there are few, if any, one billion dollar segments of the Federal budget that are buying more valuable services for the American people than that administered by the National Institutes of Health."

A report issued last year by the Secretary's Advisory Committee on the Management of NIH Research Contracts and Grants, chaired by Dr. Jack P. Ruina, President of the Institute for Defense Analysis, stated:

"In the course of its study, the committee found nothing to contradict the general opinion that the system of reviewing and funding project grants at NIH has been highly effective in the support of undirected research. Indeed, all of our findings reinforce this opinion. Without any wish to minimize certain administrative faults which have aroused congressional concern in recent years, the committee can identify no pressing need to tamper with a system that has worked so well and has presented so few major problems."

At the same time, the Advisory Committee recommended substantial strengthening of programs of directed research and program management.

Also last year, the Special Subcommittee on Investigation of the Department of Health, Education, and Welfare, chaired by Representative Paul G. Rogers, of the House Committee on Interstate and Foreign Commerce—while finding "an urgent need for NIH to strengthen its capacity for long-range planning and to improve program administration and tighten fiscal controls"—reported:

"The subcommittee found much to commend the operations of the NIH and believes that generally there are continuing, conscientious efforts to support good research and good researchers. Moreover, it was shown that over the past years there have been considerable accomplishments resulting from these efforts."

Actions are currently underway to implement the recommendations cited above.

Reviews have also been made by outside experts of programs administered by the Office of Education and other operating agencies of the Department. It is our intent to bring the best thinking available to bear on all the programs of the Department—operational as well as research—in order to assure that the intent of Congress and the interest of the public are served in the most effective and efficient way possible.

PERSONNEL

Mr. FLOOD. Another request that is always vulnerable is a request for additional personnel before an Appropriations Committee. You have increases of some magnitude in several of the salaries and expense accounts. This is a very unpleasant question but I must ask it: What would happen if Congress put a general provision in the bill limiting your Department in total to the number of employees you have this year, possibly with the exception of Social Security, for obvious reasons.

Mr. KELLY. Mr. Chairman, I think it ought to be looked at as a very serious concern to the committee to think in terms of administering a department with the kinds of responsibilities that have been assigned to the Department of Health, Education, and Welfare.

Take the $4 billion in education. There is the necessity for an effective stewardship of those moneys. We have to be able to say we have put them out under a set of procedures that assure their accountability and so we can come back and tell you how well we have done. In my own office we are asking for an increase primarily for auditing. This is an agency responsible for auditing the Department's efforts in every State.

Mr. FLOOD. But does the experience in your shop have broad application in the Department?

Mr. KELLY. I think this really runs throughout the Department. We have asked, because of the budget picture, a restrained increase in this budget. It is an increase of less than 5,000 positions.

Mr. FLOOD. The authorized positions, you mean?

Mr. KELLY. Yes. We have asked for a total of 4,691 additional positions.

Secretary GARDNER. It is difficult to carry out the intent of the legislation unless we have people to do it. That is really basically the problem.

HISTORY OF PERSONNEL CEILINGS

Mr. FLOOD. Let us have a history of the personnel ceilings imposed on you this year. For instance, what is your current ceiling? You have a ceiling compared with the positions that you have been allowed by Congress. Give me the total now and then put the table in the record.

Mr. KELLY. It is about 104,000.

Mr. FLOOD. Put the table in the record.

Mr. KELLY. The number of positions you authorized is about 105,000 but this would compare favorably with the man-years.

Mr. FLOOD. Did anybody tell you to expect a ceiling for 1968?

Mr. KELLY. Yes, we have been given a ceiling for 1968.

Mr. FLOOD. What is it?

Mr. KELLY. The figure is 107,600 compared to the number of positions in the budget of 109,759 positions, but this, again, compares favorably with the man-years. Here again I can put a table in the record.

Mr. FLOOD. Yes, give us a table by appropriation.

Mr. KELLY. Could I make it by operating agency?

Mr. FLOOD. Yes.

Mr. KELLY. That is the way we administer it.

(The table follows:)

SUMMARY TABLE.—*Emptoyment detail, fiscal years 1966–1968 (excludes 1967 supplementals and overtime equivalents)*

	1966			1967			1968		
	Positions	Man-years	End-of-year employment	Positions	Man-years	End-of-year employment	Positions	Man-years	End-of-year employment
Food and Drug Administration	4,994	4,150	4,810	5,366	4,857	4,800	5,554	5,125	5,170
Office of Education	2,570	2,197	3,196	2,914	2,671	3,070	3,234	3,071	3,280
Vocational Rehabilitation Administration	352	284	395	421	376	440	469	429	482
Public Health Service	36,383	33,418	36,926	39,103	37,273	39,583	41,971	40,435	42,042
St. Elizabeths Hospital	3,852	3,741	3,986	4,102	3,859	4,278	4,102	4,077	4,278
Social Security Administration	44,641	42,662	45,897	48,242	46,506	48,282	49,681	47,937	49,542
Welfare Administration	1,390	1,136	1,357	1,437	1,311	1,400	1,563	1,471	1,530
Administration on Aging	99	61	88	104	93	98	122	106	114
Freedmen's Hospital	860	978	1,056	877	1,041	1,106	-------	-------	-------
Office of the Secretary	2,160	1,830	2,099	2,502	2,315	2,460	3,063	2,767	2,988
Total, DHEW	97,301	90,457	99,810	105,068	100,302	105,517	109,759	105,418	109,426
Net adjustment for overallocation	-------	-------	-------	-------	-------	−1,517	-------	-------	−1,826
Budget Bureau ceiling	-------	-------	-------	-------	-------	104,000	-------	-------	107,600

PAY ACT COSTS

Mr. FLOOD. How about your Pay Act costs for 1967? How much are you absorbing?

Mr. KELLY. For the pay which comes from appropriated funds we are absorbing 50 percent of the increased cost.

Mr. FLOOD. Give me a complete table reflecting your absorption.

Mr. KELLY. All right.

(The table follows:)

Analysis of 1967 pay cost increases and supplementals required because of civilian, military, and wage-board pay raises

	Pay cost increases					Absorption	Supplemental requested
	Civilian and administrative	Military	Wage board	Scientists and engineers	Total		
Food and Drug Administration:							
Salaries and expenses	$1,806,400			$185,400	$1,991,800	$500,800	[1] $1,491,000
Revolving fund for certification	72,400			7,600	80,000	80,000	
Advances and reimbursements	3,600				3,600	3,600	
Total, Food and Drug Administration	1,882,400			193,000	2,075,400	584,400	1,491,000
Office of Education:							
Elementary and secondary education activities	14,240				14,240	14,240	
Higher educational facilities construction	81,866				81,866	81,866	
Assistance for school construction	18,892				18,892	18,892	
Salaries and expenses	768,760			23,867	792,627	52,627	740,000
Civil rights educational activities	28,195				28,195	195	28,000
Total, Office of Education	911,953			23,867	935,820	167,820	768,000
Vocational Rehabilitation Administration:							
Research and training	700				700	700	
Salaries and expenses	115,000				115,000	115,000	
Advances and reimbursements	4,300				4,300	4,300	
From social security trust fund	(6,000)				(6,000)	(6,000)	
Total, Vocational Rehabilitation Administration	120,000				120,000	120,000	
Public Health Service:							
Community Health:							
Injury control	$58,200	6,500			64,700	64,700	
Chronic diseases and health of the aged	238,000	62,000		924	300,924	300,924	
Community health practice and research	88,400	22,800			111,200	111,200	
Communicable disease activities	357,400	79,000	47,000	28,400	512,800	511,800	
Control of tuberculosis	74,500	5,900		1,400	81,800	81,800	
Control of venereal diseases	203,000	10,700		1,600	215,300	215,300	
Dental services and resources	57,100	20,600			77,700	77,700	
Medical care services	25,800	7,000			32,800	32,800	
From social security trust fund	(50,000)	(15,000)			(65,000)	(65,000)	
Nursing services and resources	32,200	16,200			48,400	48,400	
Hospital construction activities	94,000	9,500		1,500	105,000	105,000	
Construction of health educational facilities	14,800	4,300			19,100	19,100	
Total, Community Health	1,243,400	244,500	47,000	33,824	1,568,724	1,568,724	

See footnotes at end of table, p. 53.

Analysis of 1967 pay cost increases and supplementals required because of civilian, military, and wage-board pay raises—Continued

	Pay cost increases					Absorption	Supplemental requested
	Civilian and administrative	Military	Wage board	Scientists and engineers	Total		
Public Health Service—Continued							
Environmental Health:							
Environmental health sciences	$64,700	$9,600	$4,000	$5,239	$83,539	$83,539	
Air pollution	225,500	32,100		26,455	284,055	284,055	
Environmental engineering and sanitation	115,500	36,700		4,517	156,717	156,717	
Occupational health	51,400	14,000		6,028	71,428	71,428	
Radiological health	130,800	63,600	7,700	7,929	210,029	210,029	
Total, Environmental Health	587,900	156,000	11,700	50,168	805,768	805,768	
Bureau of Medical Services:							
Hospitals and medical care	2,324,200	351,800	348,000		3,024,000	546,000	$2,478,000
Foreign quarantine activities	332,000	18,000	52,000		402,000	222,000	180,000
Indian health activities	1,333,500	188,500	498,000		2,020,000	155,000	1,865,000
Construction of Indian health facilities	4,200				4,200	4,200	
Total, medical services	3,993,900	558,300	898,000		5,450,200	927,200	4,523,000
National Institutes of Health:							
General research and services	97,600	9,700	5,000	7,300	119,600	119,600	
National Institute of General Medical Sciences	69,300	5,300	3,000	300	77,900	77,900	
Biologic standards	78,500	9,600	10,200	1,100	99,400	99,400	
National Institute of Child Health and Human Development	94,300	22,500	2,000	3,674	122,474	122,474	
National Cancer Institute	566,000	100,000	100,000	17,150	783,150	783,150	
National Institute of Mental Health	453,000	74,000	52,000	4,000	583,000	583,000	
National Heart Institute	290,100	53,700	56,400	6,250	406,450	406,450	
National Institute of Dental Research	88,300	25,700	9,000	2,600	125,600	125,600	
National Institute of Arthritis and Metabolic Diseases	286,200	55,900	45,000	15,050	402,150	402,150	
National Institute of Allergy and Infectious Diseases	261,000	46,000	58,400	3,900	369,300	369,300	
National Institute of Neurological Diseases and Blindness	294,600	26,700	43,000	5,000	369,300	369,300	
Regional medical program	40,100	600		100	40,800	40,800	
Total, NIH	2,619,000	429,700	384,000	66,424	3,499,124	3,499,124	
Other:							
National health statistics	159,600	4,400		800	164,800	164,800	
National Library of Medicine	84,000	4,000			88,000	88,000	
Office of the Surgeon General, salaries and expenses	194,000	22,000		2,575	218,575	218,575	
Emergency health activities	89,000	5,000			94,000	94,000	
Operation of commissaries, narcotic hospitals	1,300				1,300	1,300	
Service and supply fund	100,000	5,000	27,000		132,000	132,000	
Working capital fund, narcotic hospitals	8,800				8,800	8,800	
Advances and reimbursements	324,600	106,800			431,400	431,400	

From social security trust fund	(500)				(500)	(500)	
Total, other Public Health Service	961,300	147,200	27,000	3,375	1,138,875	1,138,875	
Total, Public Health Service	9,405,500	1,535,700	1,367,700	153,791	12,462,691	7,939,691	4,523,000
St. Elizabeths Hospital:							
Salaries and expenses	1,044,000		403,000	150	1,447,150	452,150	995,000
Reimbursement requiring congressional action						(−52,000)	(52,000)
Social Security Administration:							
Limitation on salaries and expenses	(11,819,000)		(71,000)		(11,890,000)		[1](11,890,000)
Operating fund, Bureau of Federal Credit Unions	137,000				137,000	137,000	
Advances and reimbursements	39,000				39,000	39,000	
Total, Social Security	176,000				176,000	176,000	
Welfare Administration:							
Bureau of Family Services, salaries and expenses	209,000				209,000	209,000	
Children's Bureau, salaries and expenses	131,000				131,000	131,000	
Juvenile delinquency and youth offenses	12,000				12,000	12,000	
Office of the Commissioner, salaries and expenses	34,000				34,000	34,000	
Assistance to refugees in the United States	32,000				32,000	32,000	
Total, Welfare Administration	418,000				418,000	418,000	
Administration on Aging: Coordination and development of programs for the aging	30,400				30,400	30,400	
Freedmen's Hospital: Salaries and expenses	164,234		32,895		197,129	1,129	[1]196,000
Howard University: Salaries and expenses	252,633				252,633	62,633	190,000
Gallaudet College: Salaries and expenses	34,000				34,000	12,000	22,000
Office of the Secretary:							
Salaries and expenses, Office of the Secretary	199,800				199,800	36,800	163,000
From Social Security trust	(23,200)				(23,200)	(200)	(23,000)
Salaries and expenses, Office of Audit	117,900				117,900	22,900	95,000
From Social Security trust fund	(13,700)				(13,700)	(3,700)	(10,000)
Salaries and expenses, Office of Field Administration	72,000				72,000		72,000
From social security trust fund	(25,000)				(25,000)		(25,000)
Surplus property utilization	30,000				30,000		30,000
Salaries and expenses, Office of the General Counsel	52,500				52,500	52,500	
From social security trust fund	(35,100)				(35,000)	(35,100)	
Advances and reimbursements	21,100				21,100	21,100	
Working capital fund	85,600				85,600	85,600	
Total, Office of the Secretary	578,900				578,900	218,900	360,000
Total, general funds	15,018,020	1,535,700	1,803,595	370,808	18,728,123	10,183,123	8,545,000
Total, trust funds	(11,972,500)	(15,000)	(71,000)		(12,058,500)	(110,500)	(11,948,000)
Authorization for increased reimbursement for St. Elizabeths Hospital						(−52,000)	(52,000)
Grand total, Department of Health, Education, and Welfare	26,990,520	1,550,700	1,874,595	370,808	30,786,623	10,241,623	20,545,000

[1] Items transmitted in H. Doc. 83 of Mar. 13, 1967. All other proposed pay supplementals were transmitted Mar. 23, 1967.

SAVINGS

Mr. FLOOD. Concerning the savings that have been discussed, were these forced savings or the natural result of late appropriations so you could not fill the positions until later than intended.

Mr. KELLY. The large sums I talked about were forced savings through deferrals and so forth, but every place we could capture savings that resulted from late appropriations they were taken advantage of. Some were savings that would have occurred in any event, but the important thing we did was we prevented the savings that occurred in that way from being reused for some other purposes and impounded the funds.

Mr. FLOOD. Do you continue this in 1968 or are the 1968 requests intended to recoup or pick up the 1967 savings?

I guess your table on the pay costs would reflect that.

Mr. KELLY. Yes, and the 1968 budget by and large reflects the plan of expenditures we have taken into consideration this year and we have no reason to believe there will be a repetition of this year's problem of combating inflation.

Mr. FLOOD. I have seen a lot of that, as you can imagine.

MEDICAID PROGRAM

The medicaid program, Mr. Secretary, has come in for considerable attention in the last several months. First, what was the estimated cost in the original budget for 1967, what is the current estimate for 1967, and what is your estimate for 1968 on medicaid? This really got a lot of attention, largely because of the New York law.

Secretary GARDNER. It was $200 million, was it not?

Mr. KELLY. You take all of the forms of medical assistance—medicaid and the vendor medical payments—made under the other titles of the bill to put it on a comparable basis. We originally estimated we would spend $795 million.

Mr. FLOOD. That was the original 1967 proposal?

Mr. KELLY. Yes.

Mr. FLOOD. What is it now, for 1967?

Mr. KELLY. $1,133,000,000.

Mr. FLOOD. What about 1968?

Mr. KELLY. $1,205,000,000.

Mr. FLOOD. Where is it going? All to New York and California? I have been hearing about New York, but I am told California is more expensive than New York.

Mr. COHEN. California is this year spending more money than New York.

Mr. FLOOD. How did they get away from the spotlight?

Mr. COHEN. I think they got away from the spotlight because there was such a sharp difference of opinion in New York between the people in New York City and upstate New York with regard to the eligibility conditions, and I do not think there was this same difference of opinion in California. The eligibility differences are less in California than in New York. I think California has a higher unit cost of medical care and a higher degree of utilization, so the dollar cost will be a lot more. There just has not been, in Congress or elsewhere, the concern about California that developed in New York.

Mr. FLOOD. I know. I was just wondering why. Of course the historical division in New York probably accounts for it and the classical division between north and south California would not apply to this, would it?

Mr. COHEN. I think California has always had a much more liberal tradition with regard to medical care than New York has. For instance, Governor Warren, when he was Governor in 1940, actually recommended a State compulsory health insurance program in California and their Blue Cross and other insurance programs have always been very extensive. So I think California has a wider degree of acceptance of the idea of more liberal health plans.

PROPOSED CHANGES IN THE LAW

Mr. FLOOD. In reference to medicaid, is this a good program, is the whole thing a mistake, or is part good and part bad? What kind of changes are you proposing?

Secretary GARDNER. I think it is a very good piece of legislation. I think there was a failure to foresee the cost of this and we are proposing one or two changes that may bring that down, the major one of which is that the medical assistance eligibility level not be greater than 150 percent of the State's own poverty or public assistance level.

Mr. FLOOD. That varies State by State?

Secretary GARDNER. That varies State by State but these would be linked together.

Mr. FLOOD. Could they ever be made uniform? Would that be possible?

Secretary GARDNER. That is pretty hard with the varying economic levels of the States. There are tremendous variations.

Mr. FLOOD. But you think it is good, do you?

Secretary GARDNER. We believe it is a good piece of legislation if we can get it into shape.

PARTICIPATION OF STATES IN MEDICAID

Mr. FLOOD. How many States are operating under it?

Mr. COHEN. About half of the States. And I will say this, we do have the larger States in. I think this should be understood, and Chairman Mills brought this out last year in the hearings: What do you intend to happen when you have new programs if the States who have been doing it on their own come in and take advantage of the Federal grant first? New York and California and a couple other States had been operating those programs on a very extensive basis.

Mr. FLOOD. I don't know how this program got through Congress without attracting more attention.

Mr. COHEN. The reason is, I think, because there was such a tremendous controversy over medicare that the provisions for medicaid did not receive as widespread public attention.

GRANTS TO STATES FOR PUBLIC ASSISTANCE

Mr. FLOOD. The appropriation "Grants to States for public assistance" has gone up from less than $2 billion in 1959 to an estimate of $4,240 million in 1968. During that same period social

security benefits have been liberalized. We have spent billions on all sorts of programs aimed at reducing dependency and yet we have these figures. How about it?

Secretary GARDNER. Several things have happened. The date was 1959 that you mentioned?

Mr. FLOOD. Yes.

Secretary GARDNER. One is that since 1959 a great many States have liberalized their provisions so that they let more people on the rolls. Another thing is the population increase. Then I think recently another factor has come into it and that is that the very active efforts on the poverty fronts have made a variety of people more aware of the benefits that were available and have led them to come in and seek their benefits. We always have known there are far more people on the poverty level than are on the welfare rolls. The welfare program only catches a fraction of those.

Mr. KELLY. Mr. Chairman, a couple years ago at the committee's request we put together a table that identified the changes that had occurred over the years in public assistance expenditures and the cost of those changes. I must say I was astonished when we put it together as to the extent to which it was changed by Congress having liberalized the degree of Federal participation and increased categories of eligibility. So you are not comparing the same program this year with an earlier year.

Mr. FLOOD. This is the apples and oranges business?

Mr. KELLY. I think it would be helpful to the committee by adding, for instance, the category of dependent parents and adding medicaid. It is not just that there have been large increases in the same program. By and large the program for the aged has declined as social security has increased. In 1968 there will be fewer than 2 million recipients. The other adult categories have tended to remain about the same, and the large increase has been in the number of dependent children. There is a strong correlation with the expanded population.

Mr. FLOOD. Of course Mr. Natcher could expand on that a great deal as it applies to the city of Washington, since he is chairman of the District of Columbia Appropriations Subcommittee.

Mr. NATCHER. Off the record.

(Discussion off the record.)

SOCIAL SECURITY INCREASES RELATED TO WELFARE PAYMENTS

Mr. COHEN. Could I comment on that?

THE AGED

First let me tell you the partial successes we have had in this area, going back to your statement about the increases in social security. In 1950, 22.6 percent of the aged, specifically those 65 years of age and over, were receiving old-age assistance.

Mr. FLOOD. Old-age assistance?

Mr. COHEN. Yes. I am taking that one category.

Mr. FLOOD. You have the blind, the disabled, aid to dependent children.

Mr. COHEN. Yes. I will take up each one.

With the aged the proportion has dropped from 22.6 percent to where it is about 11 percent of the population at the present time.

Mr. FLOOD. That is due to medicare?

Mr. COHEN. No. That is due to the increase in social security cash benefits.

Mr. FLOOD. And medicare?

Mr. COHEN. Medicare has helped but what has happened in the public assistance programs over the last 15 or 17 years is that especially with regard to the aged the problem has shifted from a cash payment problem in assistance to vendor payments for medical care. If we had the same proportion of people on old age assistance today as we had in 1950 there would be 2 million more people receiving old age assistance than the 2 million we have. So that is some measure of the success we have had in the interrelationship with social security benefits.

THE BLIND

Mr. FLOOD. The Secretary said there are not as many blind people. Why not?

Mr. COHEN. A lot has been done on the prevention of blindness. There was a period of time when certain developments about 10 or 12 years ago caused a splurge of blind children because of the lack of oxygen, I think.

Mr. KELLY. From giving them high pressure oxygen.

Mr. COHEN. That has been overcome and there has been a more extensive program in the treatment of glaucoma.

Mr. FLOOD. Is there much glaucoma in the United States?

Mr. KELLY. Particularly in poor areas. It is prevalent among the Indian people.

Mr. COHEN. We have reduced the proportion of the blind from a high of 90 per 100,000 aged 18 and over in 1957 to 67 in 1966 per 100,000.

AID TO DEPENDENT CHILDREN

Mr. FLOOD. What about aid to dependent children?

Mr. COHEN. That is where the proportion of children has gone up.

Mr. FLOOD. And so has the cost?

Mr. COHEN. Yes.

Mr. FLOOD. Do you think, Mr. Secretary, this invites illegitimacy?

Secretary GARDNER. I do not think we have any evidence one way or another on that.

Mr. FLOOD. Mr. Natcher, what do you think?

Mr. NATCHER. I never have thought so, Mr. Chairman

Mr. COHEN. I do think, though, there was the problem up until 1961 or 1962 that there could be a good argument it invited breakup of the family, because up to 1961 the only aid to a child was if there were death, disability, or absence from the home, and in 1961 we added unemployment of the parent.

Mr. FLOOD. This is the so-called man-in-the-house rule, colloquially?

Mr. COHEN. Yes, colloquially. There are two aspects to the problem. One is the problem where he is bona fidely unemployed and under the old rule he would have been pushed out of the home to make it possible for assistance. Another aspect is where a new man comes in the house, not the previous father, and that presents certain problems. It is true that aid to dependent children has increased pro-

portionately. It was a high of 4 percent in 1950 and during the early part of this decade it started going over 4 percent and it is now 4.9 percent.

Mr FLOOD. Were you ever in the Sahara Desert? Did you ever get the impression in a big wind you were taking two steps forward and going back one?

Mr. COHEN. I have not been in the Sahara Desert but I have been in the Oregon sand dunes and have had the same impression.

PROPOSED SOCIAL SECURITY AMENDMENTS

Mr. FLOOD. Mr. Secretary, what social security amendments are you actively working toward?

Secretary GARDNER. We have a package of increased benefits, one of which is increasing the minimum from $44 to $70, which is a major change. Then there is a proposed increase of benefits which will bring about an average 15-percent increase across the board. Those are the two basic changes.

EXTENSION OF MEDICARE COVERAGE TO THE DISABLED UNDER 65

We also want to include the disabled under 65 in medicare, and we have one or two others.

Mr. FLOOD. You mean totally and permanently disabled?

Mr. COHEN. Yes. There are approximately 1,300,000 totally disabled.

Mr. FLOOD. Is that a lot?

Mr. COHEN. That is in the bill presently pending before the Ways and Means Committee.

Mr. FLOOD. That is not a lot of people, is it?

Mr. COHEN. 1,300,000. Then there are recommendations of bringing 70,000 disabled widows into the cash benefits.

I might say this to give you an idea of the importance of the amendments the President and the Secretary have recommended. If they are adopted it is our estimate it will result in taking 2.1 million out of poverty, 1.6 million of whom would be aged and 500,000 would be under the age of 65.

Mr. FLOOD. What is the poverty line, $3,000?

Mr. COHEN. Roughly $3,200 for a family of four. For an aged person alone it is $1,500, for an aged couple it is $1,900, and the amount is modified by size of the family. These amendments, taken together, would also have the effect of relieving the States of some financial responsibility under public assistance at the present time because it would take about 200,000 aged persons off old age assistance. It would also have the effect of probably reducing the amount of assistance, if every State did so, for about a little over 1 million persons. The States would then be free, of course, to put the money they save from this in other aspects of their welfare program to meet in part the increasing load under the medicaid program.

Mr. FLOOD. What other legislation are you proposing right now?

Secretary GARDNER. We believe our proposals this year are relatively modest fiscally but we have other proposals. For example, one proposed act would pull together a number of teacher training programs into one legislative package and aid school administrators and

one or two other categories and permit us to do a total job. We are making requests for additions in vocational education to experiment with new ways of doing the job.

Mr. FLOOD. That is research?

Secretary GARDNER. It is research and development, experimentation with new kinds of vocational programs. We need a much better link between the school and the job.

Mr. FLOOD. You are asking for a law on this?

Secretary GARDNER. Yes. The partnership for health law was passed last year but given only a 1-year authorization. This, again, is a movement to take a number of separate health programs and create a bloc grant that will permit the States to do some planning on their own in the health field and put the money where they think it ought to be.

PROGRAMS LACKING AUTHORIZATION

Mr. FLOOD. There are several programs for which you are requesting funds in 1968 that lack authorization. Will you place a list of those in the record?

Mr. KELLY. Yes, I will. We submit that as a matter of budget practice.

Mr. FLOOD. I know.

(The list follows:)

Requests in the 1968 budget for which legislative authority is due to expire before 1968

Appropriation	Program and authorizing law	1968 request under expired legislation
Office of Education:	Elementary and secondary education act of 1965:	
Elementary and secondary educational activities	Assistance for Indian children:	
	Educationally deprived children	$9,000,000
	Supplementary educational centers and services.	350,000
	Library resources	128,000
	Assistance for military dependents in overseas schools:	
	Supplementary educational centers and services.	900,000
	Library resources	415,000
National Teacher Corps	Operations and training under the Higher Education Act of 1965.	36,000,000
Expansion and improvement of vocational education.	Construction of vocational education facilities; Appalachian Regional Development Act of 1965	7,000,000
Public Health Service:		
Community health services	Grants for construction of university-affiliated facilities for the mentally retarded: Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963.	10,000,000
Hospital construction activities	Grants for construction, equipping and operation of demonstration health facilities: Appalachian Regional Development Act of 1965.	15,000,000
Community mental health resource support.	Grants for construction of community mental health centers: Community Mental Health Centers Act.	50,000,000
Welfare Administration:		
Segments of "Grants to States for public assistance."	Unemployed parent segment of aid to families with dependent children, including community work and training provisions (under title IV of the Social Security Act).	113,700,000
	Special demonstration projects grants (section 1115 of the Social Security Act).	2,000,000
Assistance for repatriated United States nationals.	Provision of temporary assistance to repatriates other than the mentally ill (sec. 1113 of the Social Security Act).	93,100
Administration on Aging: Coordination and development of programs for the aging.	Older Americans Act of 1965:	
	Title III: Grants for community planning, services, and training.	10,550,000
	Title IV, V: Grants for research, demonstration, and training.	6,400,000
Office of the Secretary: Educational television facilities.	Educational Television Facilities Act	304,000

APPROPRIATION AUTHORIZATIONS COMPARED TO BUDGET REQUESTS

Mr. FLOOD. I hear a great deal of talk about the big increases in your budget, and I read a great deal about it, and I hear my colleagues talk about it. I do not think the Members of Congress would complain so much about some of these increases if they recognized that you have exercised considerable restraint in your budget requests compared to the authorizations Congress voted. Those authorizations were voted for by huge majorities, in many instances, with sometimes not more than a corporal's guard on the other side, yet 6 months later I have heard some of the same people who voted for the authorization complain about your request for funds to carry out the authorization.

I wish you would put a list in the record of all the programs that you administer, for which you have a specific dollar authorization, and indicate what the authorization for 1968 is for each and how much you are requesting against that for each.

Secretary GARDNER. The most dramatic example is title I. The authorization for title I for elementary and secondary schools is $2.4 billion and we are requesting $1.2 billion, and we are getting some very severe criticism.

Mr. FLOOD. You are a very modest fellow, so I am inviting you to put the authorization chart on one side and what you are asking on the other.

Secretary GARDNER. Very good, sir.

(The table follows:)

Authorizations and budget estimates for fiscal year 1968 [1]

[In thousands of dollars]

	Fiscal year 1968	
	Legislative authorization	Budget estimate
OFFICE OF EDUCATION		
Elementary and secondary educational activities:		
Educationally deprived children:		
Grants to States	$2,416,898	$1,187,469
State administration	24,462	12,531
Subtotal	2,441,360	1,200,000
Supplementary educational centers and services	515,000	240,000
Guidance, counseling, and testing: Grants to States	30,000	24,500
Strengthening State departments of education:		
Grants to States	42,500	
Supervision of title III, NDEA	8,000	25,288
Statistical services	2,800	
Special projects	7,500	4,462
Subtotal	60,800	29,750
Equipment and minor remodeling:		
Grants to States	96,800	47,000
Loans to nonprofit private schools	13,200	1,000
Administration	2,000	2,000
Subtotal	112,000	50,000
Library resources	154,500	105,000
Teacher training institutes:		
Institutes	56,000	35,500
Institutes for counseling personnel	7,250	7,250
Subtotal	63,250	42,750
Total	3,375,965	1,692,000

See footnotes at end of table, p. 63.

Authorizations and budget estimates for fiscal year 1968 [1]—Continued

[In thousands of dollars]

	Fiscal year 1968	
	Legislative authorization	Budget estimate
OFFICE OF EDUCATION—continued		
National Teacher Corps	[2] $36,000	$36,000
School assistance in federally affected areas:		
1. Maintenance and operations:		
(a) Payments to local educational agencies	434,500	389,200
(b) Payments to other Federal agencies	27,000	27,000
Total	461,500	416,200
2. Construction:		
(a) Assistance to local educational agencies	52,796	12,317
(b) Assistance for school construction on Federal properties	10,000	10,000
Total	62,796	22,317
Higher educational activities:		
1. Program assistance:		
(a) Strengthening developing institutions	55,000	30,000
(b) Colleges of agriculture and the mechanic arts	11,950	11,950
(c) Undergraduate instructional equipment and other resources:		
(1) Television equipment	10,000	1,500
(2) Other equipment	60,000	13,000
Subtotal	70,000	14,500
2. Construction:		
(a) Public community colleges and technical institutes	167,440	89,700
(b) Other undergraduate facilities	560,560	300,300
(c) Graduate facilities	120,000	50,000
(d) Loans, NOA	400,000	
Obligations from 1967 NOA		(100,000)
Participation sales	(100,000)	(100,000)
Program level	(500,000)	(200,000)
(e) State administrative expenses	7,000	7,000
Subtotal	1,255,000	447,000
3. Teacher education:		
(a) Elementary and secondary teacher programs:		
(1) Experienced teachers		15,000
(2) Prospective teachers	275,000	12,500
Number of new fellowships	(10,000)	(3,215)
(3) Strengthening graduate programs		7,500
Subtotal	275,000	35,000
(b) College teacher fellowships		
Number of new fellowships	(7,500)	(5,460)
(c) Institutes in use of equipment and other teaching aids	5,000	2,500
4. Student aid:		
(a) Educational opportunity grants:		
(1) Grants to institutions	[3]	155,600
Amount of new awards	(70,000)	(58,100)
(b) National defense loans:		
(1) Contributions to loan funds	225,000	190,000
(2) Loans to educational institutions	[4]	2,000
(c) Work-study programs	200,000	139,900
Expansion and improvement of vocational education:		
1. Vocational training:		
(a) Vocational Education Act of 1963	202,500	199,309
(b) George-Barden and supplemental acts	49,991	49,991
2. Appalachian regional development	[5] 7,000	7,000
3. Student aid:		
(a) Direct loans	1,000	
(b) Work-study programs	35,000	
Libraries and community services:		
1. Library services:		
(a) Grants for public library services	45,000	35,000
(b) Interlibrary cooperation	7,500	2,375
(c) State institutional library services	7,500	2,120
(d) Library services for physically handicapped	4,000	1,320
2. Construction of public libraries	50,000	27,185
3. College library resources	50,000	25,000
4. Acquisition and cataloging by Library of Congress	7,770	4,000
5. Librarian training	[6] 15,000	8,250

See footnotes at end of table, p. 63.

Authorizations and budget estimates for fiscal year 1968 [1]—Continued

[In thousands of dollars]

	Fiscal year 1968	
	Legislative authorization	Budget estimate
OFFICE OF EDUCATION—continued		
Libraries and community services—Continued		
6. University community service program	$50,000	$16,500
7. Adult basic education	60,000	44,200
Educational improvement for the handicapped:		
1. Preschool and school programs	154,500	15,000
2. Teacher education	34,000	24,500
3. Research and demonstrations	12,000	11,100
4. Captioned films for the deaf	5,000	2,800
Total	205,500	53,400
Research and training:		
1. Educational laboratories and research and development centers: Construction	([6])	
2. Research:		
(a) Vocational education	22,500	17,100
(b) Foreign language education	[7] 18,000	3,000
(c) Educational media	5,000	4,400
(d) Library improvement	[8] 15,000	3,550
Arts and humanities educational activities:		
1. Instructional assistance:		
(a) Grants to States	440	440
(b) Loans to nonprofit private schools	60	60
2. Teacher training institutes	500	600
Total	1,000	1,000
Colleges for agriculture and the mechanic arts: Grants to States	2,550	2,550
Promotion of Vocational Education, act of Feb. 23, 1967: Grants to States	7,161	7,161
VOCATIONAL REHABILITATION ADMINISTRATION		
Grants for rehabilitation services and facilities:		
Vocational rehabilitation services	400,000	287,000
Inovation of rehabilitation services	9,000	3,200
Construction of facilities and workshops	9,000	3,850
Workshop improvement activities	14,000	10,000
Expansion of vocational rehabilitation services		7,500
Research and training:		
Research and demonstrations	117,000	21,850
Training		32,534
Special Center program		10,950
Grants for correctional rehabilitation study	800	800
National Commission on Architectural Barriers	250	250
PUBLIC HEALTH SERVICE		
Health manpower:		
Health manpower education and utilization:		
Nursing services and resources:		
Nurse traineeships	11,000	10,000
Prospects for improvement of nurse training	4,000	4,000
Payments to diploma schools of nursing	10,000	3,000
Nurse opportunity grants	5,000	5,000
Health manpower educational services:		
Training grants:		
Public health traineeships	10,000	8,000
Allied health traineeships	2,500	1,500
Grants to schools of public health	5,000	3,500
Project grants for graduate public health training	7,000	4,500
Health professions educational improvement	60,000	57,500
Allied health professions educational improvement	13,000	9,750
Development of new methods	2,250	1,000
Student loans:		
Health professions	25,000	15,000
Veterinary medical education	1,000	
Nurses	25,300	16,000
Scholarships	8,200	8,200
Construction of health educational facilities:		
Construction of teaching facilities for medical, dental, and other health personnel	185,000	175,000
Construction of teaching facilities for nurses	25,000	25,000
Construction of teaching facilities for the allied health professions	9,000	3,000
Disease prevention and environmental control:		
Communicable diseases: Grants for community immunization	11,000	9,100
Air pollution	66,000	64,185
Urban and industrial health: Solid waste disposal	19,200	15,602

See footnotes at end of table, p. 63.

Authorizations and budget estimates for fiscal year 1968 [1]—Continued

[In thousands of dollars]

	Fiscal year 1968	
	Legislative authorization	Budget estimate
PUBLIC HEALTH SERVICE—continued		
Health services:		
Community health services:		
Grants for construction of university affiliated facilities for the mentally retarded	[4] $10,000	$10,000
Grants for construction of public and other nonprofit facilities for the mentally retarded	30,000	15,000
Health services for migratory workers and their families	9,000	8,100
Hospital construction activities:		
Hill-Burton grants for construction of health facilities	280,000	280,000
Studies and demonstrations relating to coordinated use of hospital facilities	10,000	10,000
Grants for the construction and operation of demonstration health facilities in Appalachia	[4] 15,000	15,000
Indian health activities: Special assistance to the Menominee Indian people	350	350
National Institutes of Health:		
Regional medical programs: Grants	200,000	59,400
Grants for construction of health research facilities: Health research facilities	230,000	35,000
National Institute of Mental Health:		
Community mental health resource support:		
Grants for construction of community mental health centers	[4] 50,000	50,000
Grants for staffing of community mental health centers (authorization is for new grants only)	[4] 30,000	20,000
Public Health Service, other:		
National Library of Medicine:		
Grants for library construction	10,000	5,000
Training in medical library sciences	1,000	1,000
Assistance to special scientific projects	500	100
Research and development in medical library sciences	3,000	1,600
Grants for improving and expanding basic resources of medical libraries	3,000	2,500
Grants for regional medical libraries	2,500	1,500
Support of biomedical scientific publications	1,000	800
Regional branches of the National Library of Medicine	2,000	----------
Comprehensive health planning and services:		
Grants to States for comprehensive State health planning	5,000	5,000
Project grants for areawide health planning	7,500	7,500
Project grants for training, studies, and demonstrations	2,500	2,500
Grants for comprehensive health services	62,500	62,500
Project grants for health services development	62,500	62,500
WELFARE ADMINISTRATION		
Grants for maternal and child welfare:		
Maternal and child health services	55,000	50,000
Crippled children's services	55,000	50,000
Child welfare services	55,000	46,000
Special project grants for maternity and infant care	30,000	30,000
Special project grants for health of school and preschool children	40,000	40,000
Training of professional personnel for the care of crippled children	10,000	7,000
Research projects relating to maternal and child health and crippled children's services	8,000	6,120
ADMINISTRATION ON AGING		
Coordination and development of programs for the aging:		
Community planning, services, and training	[4] 10,550	10,550
Grants and contracts for research, demonstration, and training	[4] 6,400	6,400
OFFICE OF THE SECRETARY		
Higher education for international understanding:		
Grants for undergraduate international studies	40,000	5,950
Grants for advanced international studies		13,000
Language and area programs (Title VI, NDEA)	[7] 18,000	12,700
Educational television facilities	[4] 20,000	20,000

[1] Includes only those programs having specific amounts authorized.
[2] Authorization contained in proposed extension legislation. Current authority expires on June 30, 1967.
[3] New awards and construction costs.
[4] $25,000,000 for duration of act.
[5] The $15,000,000 is the total authorization for both library training under "Higher educational activities" and library research under "Research and training."
[6] $100,000,000 for 1966–70.
[7] The $18,000,000 is the total authorization for both foreign language research under "Research and training" and language and area programs under "Higher education for international understanding," Office of the Secretary.

CIVIL DEFENSE

Mr. FLOOD. You know what the attitude of this subcommittee has consistently been about the practice of scattering requests for civil defense appropriations among the budgets of several Departments. This is an old chestnut.

If there are any funds for this purpose in this budget will you set them forth at this point?

Mr. KELLY. I think I have that for you.

(The list follows:)

The Department of Health, Education, and Welfare requests funds for civil defense purposes in only one account, the appropriation "Emergency health, and welfare activities". The request for this account is submitted to the Appropriations Sub-committee on Independent Offices and the Department of Housing and Urban Development.

PROGRAMING PLANNING AND BUDGETING

Mr. FLOOD. Here is something that amazed me a little bit. In your justifications for the appropriation "Hospitals and Medical Care" you are requesting an increase of $100,000 and eight positions which you say:

Will provide staff capability to meet the demands generated by the planning, programing and budgeting system being instituted in this office.

Why an increase of $100,000 in one appropriation?

Secretary GARDNER. This is a planning, programing and budgeting system. This is now by order of the President being done in every agency and Department. I think we have probably the best man one could find to do that. He has done some extremely valuable services.

Mr. KELLY. The hospital one is particularly a good one. Here we are operating a system of hospitals. That is what these positions deal with. They will make cost-benefit studies to determine the most efficient systems for carrying out their responsibilities. If they are good at it and if the results of this are really worthwhile, the opportunity to disseminate these findings to the whole Nation's hospital system is really well worth looking at. If we can improve and perfect our method of operating these hospitals, that is. The Secretary and the President have directed the Surgeon General to use these Public Health Service hospitals as a laboratory to study how you can best provide medical care.

Using this tool, it seems to us, is a very helpful way of accomplishing that.

Mr. FLOOD. I am on two hospital boards. I will watch you.

Give me for the record what you are spending this year, and what is in your budget for next year on this, by appropriation.

Mr. KELLY. We will supply that.

(The information follows:)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Staffing increases included in the 1968 budget for program-planning-budgeting system (includes items contained in Labor-HEW appropriations bill)

Agency and appropriation	Program analysis and evaluation		Program and financial plan		Total	
	Positions	Amount	Positions	Amount	Positions	Amount
Public Health Service:						
Chronic diseases	4	$39,000	1	$7,000	5	$46,000
Air pollution	1	13,000			1	13,000
Radiological health	1	12,000			1	12,000
Hospitals and medical care	7	95,000	1	5,000	8	100,000
National Institute of General Medical Sciences	1	15,000	1	7,000	2	22,000
National Cancer Institute	2	32,000			2	32,000
National Institute of Arthritis and Metabolic Diseases			1	7,000	1	7,000
Office of the Surgeon General, salaries and expenses	6	80,100	5	29,900	11	110,00
Public Health Service management fund			6	103,000	6	103,000
National Institutes of Health management fund			2	16,000	2	16,000
Total, Public Health Service	22	286,100	17	174,900	39	461,000
Welfare Administration, Children's Bureau: Salaries and expenses	1	11,700	1	10,300	2	22,000
Administration on Aging: Coordination and development of programs for the aging			2	16,000	2	16,000
Office of the Secretary: Salaries and expenses	6	78,000	3	44,000	9	122,000
Total, Department of Health, Education, and Welfare	29	375,800	23	245,200	52	621,000

NOTE.—Definitions of the types of staffing included above are as follows (positions shown are both professional and clerical):

(*a*) Program analysis and evaluation: Staff involved in the conduct of studies and analyses to compare and evaluate the effectiveness of program alternatives and to determine the relative cost effectiveness of existing and proposed programs.

(*b*) Program and financial plan: Staff involved in the formulation, development, review, and implementation of a program and financial plan, including the data to support the plan.

CENTER FOR PREVENTION AND CONTROL OF ALCOHOLISM

Mr. FLOOD. Last October you, with great fanfare indeed, announced the establishment of a National Center for Prevention and Control of Alcoholism, and you had very good press coverage as I recall. Suppose you tell us a little about this center's current activities and what you hope to accomplish.

Secretary GARDNER. We believe this has gone along well.

A man named Jack Mendelsohn was appointed as the head. We keep very close track of it within the Office of the Secretary; Dr. Milton Silverman on Dr. Philip Lee's staff, works with Mendelsohn.

The problem is that alcoholism has just been neglected as far as research and effective attention is concerned. A lot of hospitals will not treat alcoholics. A lot of medical people just are not interested in this as a field of study. I think we are pretty well convinced that a very great deal can be done in a research way with alcoholism. A great deal can be done in more effective help to alcoholics if we just get to it. So far we are just in the organization stages.

Mr. FLOOD. What do you imagine can be done? Have you any idea?

Secretary GARDNER. I am not a physician and I would not want to say. I have believed for quite a long time that surely down the road for a fairly substantial number of cases there is some kind of chemical and physiological solution to this condition.

Mr. FLOOD. Does it not involve psychiatric care?

Secretary GARDNER. I think a fair proportion of the cases do involve psychiatric care, and if you cure them of alcoholism they will still have the problem.

Mr. FLOOD. Do you have medication in mind?

Secretary GARDNER. I do not want to pursue it because I am not a physician.

Mr. FLOOD. Suppose you ask the director of this center to comment for the record on this.

Secretary GARDNER. I shall do that. I will be delighted.

(The information follows:)

A PROGRAM IN THE FIELD OF ALCOHOLISM

For too long the urgent needs of alcoholics have been disregarded by most general hospitals, psychiatric agencies, public welfare departments, physicians in private practice, social agencies, vocational rehabilitation agencies, public health departments and other "helping" agencies. Active steps can and must be taken to ensure that alcoholics receive care and treatment from these agencies on the same basis as other persons in need of help. The very magnitude of the problem of alcoholism—and the fact that virtually all alcoholics also have other medical, psychological and social problems in addition to their difficulty with alcohol—argues against the establishment of a special network of treatment services for these patients. Such specialized services could neither be adequately staffed—because of the great manpower shortages in all health and related fields—nor could they provide the broad range of services needed by most problem drinkers.

For these reasons it is essential that the highest priority be given to ensuring that the general "helping" agencies give appropriate attention to the needs of alcoholics. Care and treatment must be of high quality, must be comprehensive, and must involve continuity between different agencies. The objective then is to secure help for alcoholics within the mainstream of American health agencies. Two recent trail-breaking legislative actions in the health field are of particular importance, in relation to this objective.

The Community Mental Health Centers Act and the Comprehensive Health Planning and Public Health Service Amendments of 1966 provide unique opportunities to ensure needed attention to the major medical-social problem of alcoholism. The services being developed throughout the country in community mental health centers will finally provide to alcoholics the emergency, inpatient, outpatient and partial hospitalization care that for too long has been unavailable to these patients. Within the comprehensive health planning activities supported under PL 89–749 it will be possible to involve an even broader range of health and health-related agencies in the provision of treatment to persons with drinking problems. One of the major current activities of the staff of the National Center for Prevention and Control of Alcoholism is to work collaboratively with Federal, State and local groups to ensure that maximum advantage is taken of these two unique opportunities to radically improve the quantity and the quality of help provided to alcoholics and their families. Already underway at the National Center is an intramural research program encompassing biological, behavioral and social science aspects of alcoholism and alcohol-related problems.

Both community mental health and comprehensive health legislation emphasize the importance of preventive approaches. This emphasis applies with equal force to the problem of alcoholism. Early case-finding of potential alcoholics followed by the provision of needed treatment is a major element in the prevention of alcoholism. Equally essential is the development of broad programs of alcohol education within American schools and communities. Finally, a substantial improvement of general mental health probably will be accompanied by a reduction in rates of alcoholism. This is because psychological factors undoubtedly are a major element in the development of alcoholism. There is no sound evidence to date to point to a biochemical or physiologic defect as the cause of alcoholism.

While many aspects of alcoholism require psychiatric assistance many other agencies also must be involved. Excessive alcohol intake can be a life-threaten-

ing emergency and often requries careful medical attention. Similarly, alcoholics suffering from physical illnesses, such as cirrhosis of the liver, need assistance from physicians. However, dealing with the basic drinking problem is a task for many different agencies, psychiatric as well as non-psychiatric, medical as well as non-medical. Community mental health programs, family agencies, public welfare departments, vocational rehabilitation agencies, and public health departments must also participate in various aspects of community programs for the prevention and treatment of alcoholism.

While progress has been made in recent years in the treatment of alcoholism there is a great need for further research. Certain drugs, such as Antabuse, Flagyl, and tranquilizers have been found useful in work with some alcoholics, but the primary emphasis remains on psychological and social therapeutic approaches that seek to help the alcoholic handle his anxiety and tension without reliance on alcohol. The objective of such treatment efforts is to improve the alcoholic's social functioning so that he can again be a fully contributing member of his family and community.

The National Center for Prevention and Control of Alcoholism, as the focal point for all activities within the Department of Health, Education, and Welfare in relation to alcoholism, will support and stimulate a wide range of research, training, education and demonstration activities by all levels of Government, by voluntary groups and by individual workers throughout the country. This will involve, for example, active collaboration with professional training and research institutions such as medical schools, schools of public health, schools of nursing, and schools of social work. Extensive in-service training programs will be developed for personnel who have already completed their basic professional education but who are not adequately trained to provide assistance to persons with drinking problems. There is good reason to believe that steps such as these, together with appropriate utilization of the opportunities presented by the recent community mental health and comprehensive health legislation, will rapidly overcome the long-term neglect and disregard of this major health problem.

ANTISMOKING PROGRAM

Mr. FLOOD. Your antismoking campaign was christened a few years ago with great fanfare and truly spectacular press coverage. Now, I do not see very much about it. Obviously it has not met with much success.

According to the Washington Evening Star last December 31:

> Americans smoked a record number of cigarettes this year.
> The Department of Agriculture forecast a further increase next year.

What happened to this great big show?

Secretary GARDNER. First, it was not a very big show compared to the amount of money spent on advertising for cigarettes. I suppose we spent $10 million.

Mr. COHEN. Less than that.

Secretary GARDNER. Less than that as against $250 million for advertising cigarettes.

I have gone into this repeatedly. I have to say that I find it hard to fault the people involved. I think they have worked very hard. They have worked very well and it is an inherently difficult task.

The absolute number of cigarettes smoked has gone up, the relative number has not. I mean the per capita consumption has not gone up. The number smoked by doctors has gone down. There is our only triumph so far. Doctors are smoking fewer cigarettes. I reviewed it about 2 or 3 months ago and concluded we had to take some further step if we are going to have any effect at all. It was at that point that we concluded that this measure of putting the tar and nicotine content on each package would be one further step because that would lead the companies to seek to reduce this competively.

There are some people in the Department, Dr. Lee, for example, who feels rather strongly there are going to be a great many people

who will never stop smoking and we must get going with the kind of research and persuade the tobacco industry to pursue the kinds of research that will result in a safer cigarette.

Mr. FLOOD. We are going to do it that way now?

The education program just did not work very well, did it?

Secretary GARDNER. It has not worked very well so far.

Mr. FLOOD. They could not have bought the advertising you fellows got free on radio, television, and press. You did not have to spend any money; it was a natural. It was all over the place.

Secretary GARDNER. When we recommended publishing the tar and nicotine content, again we got an enormous newspaper coverage. But this is a deeply ingrained habit and very hard to talk people out of.

Mr. FLOOD. I suppose while the reporter was writing his story, he burnt his finger with a cigarette.

Secretary GARDNER. We even have some of our distinguished scientists who do that when they testify. We believe the next step is the publication of the tar and nicotine content. We believe that it will bring the forces of competition to bear on reducing these harmful ingredients and, as I say, Dr. Lee feels that somehow we have got to get to a safer kind of cigarette.

Mr. FLOOD. Have you involved your education people in this at all, into the schools and colleges, and whatnot?

Secretary GARDNER. Yes, sir; we have, and the Children's Bureau has been very active on this. They have published little pamphlets on it to talk youngsters out of smoking. They carry the theme that the good athletes do not smoke and that it is not all that smart and sophisticated to smoke.

I do not know how effective those are, but they are trying.

Mr. FLOOD. You certainly are not very emotional about it this afternoon, not carried away with the thing at all today.

Secretary GARDNER. I think that is my temperament.

Mr. FLOOD. You do not take fire very rapidly?

Secretary GARDNER. I am low burning, but I will not go out.

Mr. FLOOD. Apparently the cigarettes will not either. They are still burning.

We cannot go by this just casually. You might ask Dr. Lee, your Assistant Secretary for Health to submit a statement on smoking and health for the record. This was quite a big thing in the eyes of the public for a very short time. The result is what you say it is of course, but we feel that a program that had the impact on the general public that this did cannot just be casually brushed aside.

Secretary GARDNER. I will be glad to submit that. I feel very strongly this should be pushed. I feel personally it ought to be pushed as hard as we can push it.

(The information follows:)

THE SMOKING AND HEALTH PROGRAMS OF THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

The Department of Health, Education, and Welfare carries on its smoking and health programs in full recognition that cigarette smoking is a serious health problem.

It further recognizes that if the death rate associated with cigarette smoking is to be reduced and if cigarette-related disease is to be checked, three things must take place:

1. There must be a reduction in the numbers of persons now smoking—a number which amounts to 49 million adults, or 42 percent of our adult population.

2. We must encourage young people not to start smoking. At present, half the boys and girls in this country have become cigarette smokers by the time they are 18.

3. We must work towards the development of a less hazardous cigarette—and concurrently, help develop a climate of opinion so that if such a cigarette is developed, smokers will turn to it. There is no other way to protect those millions of present smokers who probably will never be willing or able to give up smoking.

It would be indefensible to concentrate on any one goal and neglect the others. The health of 49 million present smokers is at risk, and the health of today's generation of young people who have not as yet taken up smoking. There is hope that with time, and with adequate resources, the three goals outlined above will be realized and will succeed in bringing cigarette-related disease under control. Without adequate resources and without a total approach to the problem, there is no such hope.

So far, the progress which has been made has been greatest among adult cigarette smokers. A study by the Public Health Service, as yet unpublished, suggests that currently a million adults each year are now managing to give up smoking. If there were no young people to take up the habit, this would mean a gradual reduction in cigarette consumption and the eventual end to any serious cigarette-related health problem.

Unfortunately, while large numbers of adults are giving up smoking, even larger numbers of young people are taking up the habit. (The percentage of boys and girls who begin smoking is probably no greater today than five years ago and may be somewhat less; the larger number is partly accounted for by the upturn in birth rates which occurred after World War II.)

In the face of this, our schools, health agencies and parent groups are mobilizing to meet the problem. Some 20 agencies are now joined with the Public Health Service, the Office of Education, and the U.S. Children's Bureau in a National Interagency Council on Smoking and Health. The National Council is paralleled at the State level by statewide councils and at the local level by county, city and community groups. Some State and local agencies are being supported in part by Public Health Service funds.

DEVELOPING A LESS HAZARDOUS CIGARETTE

There is no question but that many present smokers will continue to smoke for the remainder of their lives. The only way these persons can protect themselves is by smoking less hazardous cigarettes or by smoking cigarettes in a less hazardous way. There is reason to believe that a less hazardous cigarette can be developed through further research, but the problems involved are considerable and much effort will be needed. The cancer hazard is by no means the only one, but it is an important one and our approaches in this area are well defined and directed into two main areas:

1. Preparation of a less harzardous cigarette, and
2. Attempts at host modification.

It is now technically possible to remove or reduce certain constituents of cigarette smoke that are thought to be responsible in part for the carcinogenic properties of cigarette smoke. For certain other constituents, methods might be developed. Finally, an opportunity exists to reduce individual hazardous components by taking advantage of known variations in the chemical composition of the tobacco leaf itself.

It must be emphasized that the relative contribution of individual components to the hazards of cigarette smoke is essentially unknown and that unsuspected carcinogenic and irritating agents in cigarette smoke may be identified in the future. It would be unreasonable to assume that removal of all the currently known hazardous materials in cigarette smoke would result in a "safe" cigarette.

As to host modification, it is widely recognized that all persons exposed to a carcinogenic environment are not at equal risk to the development of cancer. This is true of the association of cigarette smoking with lung cancer. There is a need, arising out of this fact, to identify those biological factors that characterize susceptibility on the one hand and resistance on the other. The resulting data could provide a base for a program to protect susceptible persons from the harmful constituents of cigarette smoke.

The Surgeon General's Report on Smoking and Health identified a significant excess mortality from coronary heart disease associated with cigarette smoking, and it called attention to the fact that this excess mortality is reduced among those who have given up smoking. This suggests that the mechanisms through

which the cardiovascular effects of smoking are mediated may be reversible or alterable.

It is emphasized, however, a less hazardous cigarette will be useless unless smokers are willing to switch to the new product. This will not happen without educational effort. At the present time, for example, most smokers ignore the scientific opinion that cigarettes with low tar and nicotine levels present a less serious hazard to health than cigarettes with higher levels if these are smoked in the same way. Several of the cigarette brands which now command the greatest sale, in any case, are also those which rank among the highest in tar and nicotine.

THE DEPARTMENT'S PROGRAM

As the Department continues its smoking and health programs, it plans to concentrate its efforts in four areas:

1. Continued work is necessary in bio-medical research. Funds available to the National Institutes of Health for research primarily related to smoking and health now amount to approximately $7 million annually.

2. Continued behavioral research is necessary. It is difficult for people to give up smoking and apparently very easy for young people to begin; we need to know much more about these two processes. A systematic investigation into smoking behavior is now under way by the National Clearinghouse for Smoking and Health, a branch of the National Center for Chronic Disease Control.

The total funds now available to the National Clearinghouse for its total research, community and school programs and its health education activities amounts to $2 million annually.

3. We must continue to inform the public as to the hazards of smoking and in so doing to draw directly upon the resources and prestige of the Federal Government. The total budget now available to the National Clearinghouse for Smoking and Health—$2 million for all its work, including public education—compares to $250 million being spent annually for the advertising of tobacco products, a ratio which amounts to far less than one cent on the dollar.

It is obvious that the task of education will be a long and difficult one, dependent not on occassional, isolated major news events such as the Surgeon General's Report, but on a steady, continuous effort to give people the information they must have if they are to make intelligent, personal decisions on smoking.

4. Finally, and most important of all, we must continue to support smoking and health programs carried on by State and local health departments, school systems, and community groups. School systems everywhere today are busy with teacher training programs, curriculum revisions and classroom experiments in efforts to develop better ways of informing young people of the hazards of smoking. Youth groups, with the support of the Children's Bureau, are building smoking education into their programs. Community councils and other groups are functioning as well as their resources permit in virtually every city and county, supported by local medical societies, local school systems, health departments, parent groups, and voluntary health agencies.

Two full-scale community laboratories are now underway, supported by the Public Health Service, to test our various methods and techniques which other communities may be able to adopt later on. One of these, in Syracuse, New York, is very new; the other, in San Diego, California, has been in existence a year. It was begun under the sponsorship of the San Diego County Medical Society and now encompasses groups and agencies from throughout the area. What is being learned in this city and in Syracuse will allow other communities to organize effectively to help their citizens help themselves with the cigarette problem.

It is clear that cigarette smoking presents a special problem in health education. For one thing, there is usually a considerable lag between the time a person takes up smoking and the time serious illness is manifest. For another thing, cigarette smoking is a habit that is easy to start and hard to stop. Yet, even in the face of these obstacles, some progress has been made. It was less than 15 years ago that cigarette smoking was first identified to the general public as a serious health problem. Since then, consumption has continued to rise, but at a much slower pace than would have occurred if these facts had not become known. At the present time, cigarette consumption is almost static supported by young people who are beginning to smoke but held down by older people who are giving up the habit. With appropriate resources and continuing effort, this stalemate can be overcome.

Secretary GARDNER. As I say, we have several interests at the moment.

First, we want to make more effective our educational efforts. We are working with more and more voluntary organizations such as social agencies and PTAs and so forth. They are very willing to work with us and we will get a broader network of cooperation.

Mr. FLOOD. You have not dropped this?

Secretary GARDNER. No, this is moving along. I just do not want to oversell you on it because I think we have a long, long way to go.

Mr. FLOOD. For several years it has been the practice to place in the hearing record after the Secretary's testimony several comprehensive statements and tables on the budget and activities in such fields as the aging, mental retardation and so forth, that are conducted in various parts of your Department.

Will you have the same thing done this year?

Mr. KELLY. We will be glad to.

(The information will be found beginning on page 175.)

GSA TELEPHONE BILL

Mr. FLOOD. When did you pay your telephone bill last in HEW?

Mr. KELLY. I think quite recently.

Mr. FLOOD. My spies tell me you have not and GSA says you have not since a year ago last January. If it is true, it is quite a commentary on your handling of bills.

Mr. KELLY. We have paid it quite recently, but there was a very complex problem involved, and let me tell you what it was.

What happened is the General Service Administration has modified the system of handling telephones in a way which is far cheaper to the Federal Government. They have in effect rented the lines all over the country on which we make all of our telephone calls. But there is a problem. They send us a huge bill and we have a hundred appropriations but have not the slightest idea of how much of the phone bill belongs to each of these appropriations. The reason the system saves so much money is that it makes it unnecessary to keep any records. As a result, we and every other Government agency are faced with a severe problem of finding some reasonable method of allocating costs in accord with the usage. We are running sample on it. But we do not have any feeling of confidence that what we are now reporting to you as our costs for long-distance telephone calls on each appropriation reflects the actual use of telephones. It is really just a continuation of an historical figure. As the programs have changed emphasis and so forth, we do not know how to reflect this change. This distribution problem caused the bills to get so far behind.

Secretary GARDNER. You mean all of the money they save by not keeping records you will use up doing the sampling study.

Mr. FLOOD. This type of "saving" is not unusual.

TEACHER CORPS

There are two supplemental requests that I am sure you realize are highly controversial, and certain Members of Congress are going to argue against appropriating any funds at all for both of them. That is the Teachers Corps and International Education.

Since you are here and we are going to get into these things right after you leave, maybe you would like to take that bear by the tail right now, Mr. Secretary.

Secretary GARDNER. Start with the Teacher Corps?

Mr. FLOOD. It is up to you.

Secretary GARDNER. Yes, sir. Well, I was in on the very beginning of this.

Back in 1964 when the Johnson Task Force on Education was meeting, we had a number of scientists in and around that group. They commented on the fact that a great many of the ablest youngsters today liked to volunteer for work in the slums and that kind of thing. They want to do their share, so to speak. All of the colleges are getting voluntary movements which attract the youngsters who normally just do not go into teaching. They go on and become lawyers or doctors or something else. And these people felt that if you could develop some kind of voluntary service, you could get a number of these youngsters interested in the teaching profession. A voluntary service would attract a lot of youngsters who normally would not go into teaching to serve in the areas that needed them most.

We tried this out. We initiated the Teacher Corps, and the prediction that a lot of youngsters would be interested was very, very well borne out. We had 1200 places; we had 10,000 applications. Lots of young men, and there are not very many young men that go into teaching—lots of young men wanted to do this. The acceptance from the school districts has been extraordinary. We have just gotten reams of letters praising the program. They all want it, they are all short of teachers. It just seems to me such a natural thing.

In these disadvantaged areas, whether they are up in the hills of North Carolina or in a city slum, it is hard to get teachers. It is very, very hard to get them.

On the other hand, you have these youngsters who want to do it and they have enormous enthusiasm. The Teacher Corps just puts them together, puts the need and the willingness of these youngsters to do it.

I have a tremendous interest in this kind of volunteer service. I really think that this is the solution—although it is not fair to say the solution—but one of the important solutions to the feeling of ruthlessness and alienation, as they call it, of the young people today. Many young people do not know whether they have a place in this great big society. If we can give them a chance to serve when they want to serve and feel needed, we are doing something for them as well as something for society. And this the Teacher Corps does; the Peace Corps does it too.

So I am very, very strong on this. I think you buy an awful lot with a small amount of money with this program.

We had one unexpected dividend I never thought of and I do not think anyone who started the program thought about it. These youngsters are teaching all week and then working for their master's degree on the weekend. They are thrown in with regular education students; that is, other youngsters who are working for their master's degree. The Corps members know so much more about actually teaching than their fellow students that they are having a real effect on teacher training. The professors are saying: "Maybe we had better get our youngsters out into the schools more." The average youngster training for teaching spends most of his time in the classroom. His

only teaching experience consists of a certain amount of supervised instruction in a well-scrubbed school near the college. These kids in the Teacher Corps are coming back into the classroom with a lot of practical experience. Often they know more than the teacher does about the actual process of educating these youngsters.

So I am most enthusiastic about it. I am much more enthusiastic than I was two years ago when I first ran into the idea.

PROPOSED LEGISLATION ON TEACHER CORPS

Mr. FLOOD. You are proposing some new legislation; are you not?

Secretary GARDNER. Two particular points that I think are important.

First, although there was never any proposed Federal control, there was always the danger. This was a point of controversy. We are proposing language which just says explicitly that there will be no Federal control. In fact, if you talked with the districts that have these youngsters, they have not the slightest doubt where the control lies. They are the employers, they can fire them when they want to. There are no lines to Washington.

The members of the Teacher Corps are just recruited nationally.

The second point is that in the first year the salaries of these youngsters in many cases exceeded that of beginning teachers in the local schools. This seemed inappropriate. We are proposing an amendment so that this will not happen anymore. And this is often a hardship on the youngsters because they are going into areas in some cases where the pay is very low indeed.

But we agree essentially with the criticism. We believe these young people should not be getting any more than beginning teachers in the local schools.

Mr. FLOOD. But your premise is there is no Federal control of any sort?

Secretary GARDNER. And it is borne out by the experience of this year. You can talk to the school districts. Plenty of districts now have these youngsters and they can tell you whether they have ever gotten a single bit of control. The record is very clear on that.

Mr. FLOOD. If you feel it necessary after you leave to answer that under the circumstances, suppose you do. You may want to when you are driving down in the car.

INTERNATIONAL EDUCATION PROGRAM

What about the international education?

Secretary GARDNER. Again, this is one that I feel keenly about, because I have seen a good deal of it. We live in a world which is characterized by very grave conflict. There is no other problem in our future so important as the problem of war and peace. It is just far and away the greatest problem our generation faces. And when you ask yourself what you can do about it, what you can do that will knit together a world that is torn apart, it is very hard to find things that are constructive and that will work.

Nothing has a better record than international education, the exchange of students—and I would add, technical assistance.

By technical assistance I do not mean the whole range of foreign aid, I mean just the matter of experts who go out and tell other

countries how they can do things better, help them set up a medical school or help them grow their crops better, and so forth.

We have now had 20 to 25 years of history in these activities.

Mr. FLOOD. That is not this program, is it?

Secretary GARDNER. No. I am sorry. I am being long-winded. I am just getting to the point.

Most of those activities over the past 20 or 25 years have been carried by our colleges and universities. They are the ones who are the hosts to the foreign students at considerable expense to themselves. Hundreds of universities and colleges in this country are just out of general good will taking in foreign students at much less than it costs to educate them.

Mr. FLOOD. What is the matter with that? You do not want to discourage that, do you?

Secretary GARDNER. No; you do not want to discourage it, but this is a burden. As the burdens on the colleges and universities grow, and they are growing at a great rate as you all know from your own areas, it is harder and harder for them to carry this.

Beginning in the fifties, AID began to use the universities. Every time they wanted to help some country learn how to run its own affairs, they had to turn to the universities to develop the foreign country's agriculture or whatever else.

Again there was no attempt to help the universities build the resources to do this kind of thing. We have centers all around this country relevant to the rest of the world, such as centers on tropical medicine, centers on arid lands, agriculture, and all of that. The universities have paid for these things out of their own funds. These funds are getting pressed very badly because the universities are in an extreme financial squeeze today.

CONFUSION FROM TITLE OF PROGRAM

The International Education Act is not a foreign aid program, it is not something that sends the money overseas. It is a program to support and strengthen American institutions to do their own job better—teaching, research and practical work.

Mr. FLOOD. That is the point you have to make clear. The minute you say "international education," the Members are so busy—each man should be twins or triplets or something here you know—and they see the glaring phrase "international education" and they take for granted it is exactly what it means.

The difficulty is, I do not think the average Member knows that this is not what he thinks it is. Do you have any idea how we can show them?

Secretary GARDNER. No, I really do not, except to say it over and over again very strongly: this is a program in our own national interest. It is a program to assist us to do the kind of things we have to do as a nation living in this big complicated world.

Mr. FLOOD. But this is no foreign aid program?

Secretary GARDNER. No, it is not. It is not. All of the kinds of things we are doing overseas, whether they are technical, whether they are business, whether they are diplomatic, depend on Americans who understand what is going on. The business world is a very strong friend of these programs because they prepare youngsters for the kind of world we have to live in.

Mr. FLOOD. You have to know something about other places than just your own back yard?

Secretary GARDNER. That is right.

Mr. FLOOD. We may have trouble with this. I am just wondering how we can do something about it. There are a certain number of Members you know who will rush in when the rollcall is taken on this and ask somebody what are they voting on; if somebody says "international education" and walks away, he will vote against it because he thinks it is another foreign aid program or something of that kind.

I am not aware that you people tried to explain this to the Members or anybody else. Have you tried?

Secretary GARDNER. We have tried quite hard.

Mr. HUITT. Yes, sir. There has been quite a campaign carried on by Assistant Secretary Paul Miller in the main, who has gone to as many Members I suppose as one man can reach to explain this.

Also, the name is being changed from international education to higher education for international understanding to try to get away from the notion that it is an international aid program.

Mr. CARDWELL. It is a difficult thing. We have tried to improve the title. Our ability to use the English language to overcome the obstacle you cite has been found wanting. We turned to this term, in talking about higher education in this country——

Mr. FLOOD. You are thinking about changing the name to what?

Mr. CARDWELL. The appropriation title has actually been changed to "Higher education for international understanding."

Mr. FLOOD. Any volunteers?

Mr. CARDWELL. We still welcome any suggestions. We will even give a prize if someone will come up with a name that overcomes the point you mention.

CHINESE STUDIES

Mr. COHEN. At the time this legislation was going through, quite a number of men from universities came to see me who were interested in Chinese studies. I talked to the Secretary at the time. I was appalled to learn how little we know in the United States about what is going on in Red China. And these men came to me who were testifying in favor of that legislation——

Mr. FLOOD. The average American is simply awful at history or geography.

Mr. COHEN. Not only that, we have a tremendous problem of getting the relevant documents translated and developing a corps of trained people during the next decade who can read and study and know what Red China is about. They persuaded me.

I knew nothing about this, but these men persuaded me that unless we can do that, we are not going to be prepared in our country in the next 10 to 20 years to understand what is going on in that part of the world. I really believe if you do not know what is going on, if you read the material and do not know what they are talking about, obviously you cannot operate in such a world.

This will be a big step forward in that particular area.

Mr. HULL. Where do you get the literature for this when they do not allow anybody in there?

Mr. COHEN. There is a good deal of material coming out through both Hong Kong and through Taiwan. Quite a good deal of material.

But we do not have the people, as I understand it, who can read it and understand it and train students to evaluate reports on things like population or scientific developments.

Secretary GARDNER. The literature is not hard to get. Printed material you can get lots of because it is very hard to confine that within borders. The hard thing is to know how the system actually works. Today it is changing and is in such disruption it is hard to know what is happening.

We had a similar operation before the Iron Curtain was dropped in the forties. We knew almost nothing about the Soviet Union. It was considered necessary by everyone that we know more about this country that was causing so much turbulence.

Programs were established, one at Harvard, one at Columbia, to train people. Every possible source of information was utilized, including refugees who came out, literature that came out, and so forth. When the Iron Curtain finally went up, we had a group of people who were such experts on the Soviet Union and so fluent in the language that we sent them over there. The Government sent some of them, the foundations sent some of them to get the first experience in the country they were experts on. Of course the Soviet Union thought they were all spies, they spoke such good Russian. They are the ones today in our embassies, in our Armed Forces, in our colleges and universities teaching courses on Russian history and language. They got started at a time when it was as hard to get into Russia as it is to get into China.

Mr. HUTT. Mr. Chairman, the interest in Chinese is there. The Wall Street Journal carried a story the other day that said undergraduates are all clamoring for courses in Chinese language and want to learn it if people will teach them.

Secretary GARDNER. We have to know more about that country.

Mr. CASEY. Which dialect do they teach?

Secretary GARDNER. Probably Mandarin.

Mr. FLOOD. Probably the two chief ones, Cantonese and Mandarin.

OFFICE OF MANPOWER TRAINING

Late last summer you and I had an exchange of correspondence on what I still feel was your very arbitrary decision to close an office in your shop. You might remember that I demurred rather strongly to this. The office was the Office of Manpower Training.

In reply to my first letter you said this:

"I hope to give the manpower function its own identity and visibility, thereby furthering the aim of the legislation."

That is a very fine purpose and object. Tell me how visible is this manpower function in the Office of Education? Has anyone ever seen it, is it really there?

Do you follow the funny papers, Li'l Abner, like I do? Right now there is a strip going on about the Bashful Blobolink and nobody has ever seen it, you cannot see it. It is a great attraction and people come from all over the world to Lower Slobbovia. It is in a glass cage. You cannot see it. It is a national treasure down there in Lower Slobbovia. Has anybody ever seen this thing you told me about?

I am sure you never wrote this letter. You had not been in town long enough to be able to write a letter like that.

I wonder if you ever read it. I would not expect you to. It is an appalling answer to my great efforts.

Secretary GARDNER. I want to say, Mr. Chairman, that I am really quite familiar with the issues involved. I do not think anything has been of more concern to me than the manpower problem and our relations to it.

I have learned a tremendous amount about it since I wrote that letter which you prize so highly.

This is still in transition. I do not know what we are going to do, but it is perfectly clear we have to be more effective in our relations with the Labor Department on the manpower front. We have a very strong area of overlap. I have not successfully resolved some of our conflicts.

Mr. FLOOD. In view of what you are saying now, I will not pursue it, but I was wondering what happened to the jobs you eliminated. Did you send them over to the Labor Department or Office of Education?

Mr. KELLY. I wonder if I could say we not only did not eliminate the jobs, but we did something I think important both from your standpoint and ours. Those jobs were positions paid for with funds transferred from the Labor Department. We have modified that and in the budget before you we have taken those positions and made them part of our requests so they are not dependent upon just the administration of the manpower programs for which the Department of Labor is responsible. They are concerned with the manpower responsibility from the Secretary's standpoint. This is the staff that will provide the underpinning for the study that this committee directed.

Mr. FLOOD. Both sides, ever since I have been on this subcommittee, have been very much interested in manpower training. I was cosponsor with Senator Clark of Pennsylvania of the original act and I know Mr. Laird is interested in this kind of thing. I do not know about the new men, but I gather they have the same impression. That is the atmosphere that has been in this room for some time.

You will recall Mr. Fogarty, after you took this arbitrary action, put the jobs back. Just to show you how far we went, it was done unanimously. So you did more than merely ruffle our tailfeathers.

COST OF PROPOSED LEGISLATION

Mr. MICHEL. Mr. Secretary, may I first compliment you on a very fine comprehensive statement.

I think in some of the areas where you put some particular emphasis that you obviously sense what this subcommittee, not only this year, but in prior years, has been confronted with.

We are under the gun. Here we have in this bill the goodies, the dangling carrot of Federal aid for a variety of popular programs where some tell the people every 2 years they are giving them more for nothing or just a fraction of what they are paying. So here we are confronted this year particularly with a tight budget situation and have to cut it some place or it will be completely out of kilter. Nevertheless, we do not want to destroy good sound ongoing programs. But as you have suggested by your own admission, you have been reluctant to ask for full funding over and above because of the pressure being brought on you. Does the Department's budget reflect the cost of proposed or pending legislation?

Secretary GARDNER. Yes, sir.

It is $179 million total in general funds and $4,140,000,000 in trust funds.

Mr. MICHEL. If it has not been laid out up to this point in answer to the chairman's question, will you set it out here?

(The requested information follows:)

I. Education legislation:

A. Elementary and secondary educational activities $15,000,000

Comprehensive educational planning. Legislation will be proposed amending the Elementary and Secondary Education Act to provide grants to State and local education agencies for critical evaluation of existing educational programs, analysis of possible alternatives and long-range planning for necessary improvements.

B. Expansion and improvent of vocational education 30,000,000

Innovative vocational education programs. Legislation will be proposed for project grants to finance innovative programs for occupational education, including special attention to needs at the junior high school level, work experience opportunities for high school youth, curriculum improvement, and cooperative relationships with the U.S. Employment Service.

C. Higher educational activities 2,000,000

Sale of NDEA student loans to participations sales pool. Legislation will be proposed to authorize colleges and universities to borrow loan capital for their NDEA direct student loan funds and to authorize sale of certificates of participation in pools of these loans. It is proposed that proceeds from the sale (estimated at $100,000,000 for 1968) be placed in a revolving fund, and that such receipts be made available for new loans to colleges and universities. The Federal National Mortgage Association will be authorized to serve as trustee for these sales.

D. Educational television facilities 20,000,000

Legislation will be proposed to extend and broaden Federal support for educational television.

II. Health and welfare legislation:

A. Comprehensive health planning and services 25,000,000

Partnership for health. Legislation will be proposed to expand the Comprehensive Health Planning and Public Health Services Act of 1966 to provide increased grants for use by the States, and other public and nonprofit agencies, in such problem areas as family planning, laboratory licensing, and the development of improved methods of delivering health services.

B. Grants to States for public assistance 25,000,000

Title XIX revisions, —$35,000,000; Improvements in cash assistance programs +$60,000,000. Legislation will be proposed to assure that public assistance payments more nearly meet the economic needs of recipients, to require all States to provide assistance to families with children who are impoverished because of unemployment of a parent, to provide incentives for employment, and to improve work and training programs to help restore recipients to independence. In addition, legislation will be proposed to improve the medicaid for children and bring medical payments made under this program in line with those of other public assistance categories. Because of the time required to fully implement this new legislation, additional Federal costs in 1968 will begin at $60,000,000 and will be offset by anticipated savings in the medical vendor program by $35,000,000.

II. Health and welfare legislation—Continued			
C. Grants for Maternal and Child Health			$38, 000, 000
Improvements in child health programs. Legislation will be proposed to provide under the crippled children's program periodic health examinations and followup treatment for needy children (coordinated with services to be financed under title XIX) to prevent or lessen the severity of crippling childhood illnesses; establish pilot projects to concentrate on innovation in delivering child health care and in training professional personnel and medical assistants; develop dental care programs for children; and increase funds available for maternity and infant projects to expand the attack on high infant mortality rates.			
III. Social security legislation:		*Trust fund*	
A. Increased retirement and survivors benefits		$3, 619, 000, 000	
B. Increased disability insurance benefit payments		276, 000, 000	
C. Increased health insurance benefits		185, 000, 000	24, 000, 000
D. Administrative expenses		60, 000, 000	
Total		4, 140, 000,000	24, 000, 000
Legislation will be proposed for a major improvement in in the social security system and to extend the health insurance program to disabled beneficiaries. The General Fund amount above is the contribution required to pay the $3 per month Federal matching premium to cover doctor bills for the disabled. The proposed increases in social security payments is expected to reduce the need for some individuals to be assisted under other existing State and Federal income maintenance programs.			

FUTURE COSTS OF NEW LEGISLATION

Mr. MICHEL. I am sure you folks do a lot of prognosticating in gathering of statistics. The thought occurs to me, do you have any studies on what these program costs are going to be 5 or 10 years from now.

Mr. COHEN. There was a congressional committee just last year—I do not remember whether of House or Senate origin—that asked us for 5-year estimates of various programs primarily on the construction side, but not entirely limited to that. We gave them our best thinking as to what the population growth would be, the needs, and so forth. That report is available.

Mr. MICHEL. You would cite that in the records?

Mr. COHEN. Yes.

Mr. MICHEL. I would be interested in it.

Mr. COHEN. The Joint Economic Committee is the one.

Mr. MICHEL. Just for 5 years?

Mr. COHEN. I think it was 1967 or 1968 to 1972.

(The information requested follows:)

The information referred to will be found in the following congressional reports, 89th Congress, 2nd session:

(1) "Federal Programs for the Development of Human Resources", Subcommittee on Economic Progress of the Joint Economic Committee, Volume 2, part III, pages 459–950.

(2) "State and Local Public Facility Needs and Financing", Study prepared for the Subcommittee on Economic Progress of the Joint Economic Committee, Volume 1, Public Facility Needs, pages 342–519, 625–641.

TOTAL COST OF PROGRAMS IN FISCAL YEAR 1967

Mr. MICHEL. What will be the total cost for running the Department of HEW in this current fiscal year both on an expenditure and an appropriation basis?

Mr. KELLY. The appropriations this year will be $12.3 billion, and the expenditures are $10.7 billion. The request for fiscal year 1968 is $1 billion higher both in appropriations and in expenditures.

EFFECT OF 5-PERCENT REDUCTION IN BUDGET

Mr. MICHEL. Mr. Secretary, what would be the effect of a 5-percent cut across the board?

Secretary GARDNER. Right across the board?

Mr. MICHEL. Yes.

Secretary GARDNER. I think it would produce the loudest public howl you have heard in quite a long time. These programs are very deeply rooted in the schools and hospitals and clinics and institutions of the country. They build these programs into their budgets and it would be quite a serious thing.

Mr. MICHEL. Would you say we have locked ourselves inextricably into some of these programs?

Secretary GARDNER. We have locked ourselves into many of them, and it is inherent in the Federal-State partnership that we do in many of them, because the essence of a partnership is some kind of predictability. If we pull the rug out we hear from them.

SALES PARTICIPATION CERTIFICATES

Mr. MICHEL. I believe that I recall in your testimony a reference to resorting to sales participation certificates.

Secretary GARDNER. Yes, sir.

Mr. MICHEL. For the college loan program. In how many programs would you do this?

Mr. KELLY. Three programs. Higher education facilities loans involving about $200 million, the student loan program in the health professions, and the student loan program for nurses.

Mr. MICHEL. In total, you are talking about what?

Mr. KELLY. $215 million.

EFFECT OF LATE APPROPRIATIONS

Mr. COHEN. May I go back to the point you raised before and bring out to the committee this point: that the school budget is usually determined by April or May for the following year. Some State legislatures are on a biannual basis, some annual, some already have gone home. So much, as the Secretary said, of what we do relates to State and local financing for health and education and welfare that if you make any kind of a cut they are not able to come back to deal with it. In other words, the Federal Government's budgetary cycle does not fit into the State and local budgetary cycles well enough to be able to make a cut really related to the provision of services, as I see it.

Mr. MICHEL. We discussed that in some detail a little bit earlier with several of the other witnesses I know. There is also another factor here. I am reminded of last fall when we were appropriating really on the full knowledge that the authorizing legislation was about to come forward. We were in that kind of a bind. Nevertheless, also

having enacted these things, there was a timelag in your shop in processing some of these requests for grants and loans. There would be some who say well, it takes an awful long time to get your shop down there cranked up on some of these requests.

What do we say in answer to that? It is easy, of course, for you folks to come and say Congress did not give us the money on time.

Mr. KELLY. I do not think it is a one-way street at all. I do not think the person can say the problem is late legislative enactment or late appropriation. But I do think that the problem has become sufficiently acute so that we have to find some better solution to the problem of bringing the Federal structure and the time it takes to accomplish things into closer harmony with the time cycle of the people that use the funds.

In some cases we found very good accommodations. As you know, in our research programs we fund projects not for a Federal fiscal year but for 12 months from the time the project starts. Most of the fellowships and training programs you have gotten on an advanced basis so that this year we can make a selection of trainees and then the new appropriation pays for their going to school next year.

When you do business with the States, particularly the local educational system, we have to find some better way of handling these problems of timing.

Mr. CARDWELL. Many of our programs are formula grant programs. The allocations against those formulas, during the remainder of the fiscal year, from appropriations made in November, we would make in January or February. On the appropriations in full, if they were made in July on time, we would make allotments in July or August.

Mr. MICHEL. I think I could cite some examples of formulas finalized last fall and not allocated until March.

Mr. CARDWELL. There was a legislative change, the formula was changed; new data requirements were introduced. Those things delayed the allocation. But all the funds were allocated in the compressed fiscal year that remained following congressional action.

5-PERCENT REDUCTION IN BUDGET

Mr. KELLY. Could I go back to the 5-percent across the board and comment on it?

Mr. MICHEL. All right.

Mr. KELLY. There are two points that should be made. One is that this budget does recognize the kind of financial condition that exists, the fact there was the Vietnam situation and that there was a threat of inflation. This budget is not near where we thought it would be for this fiscal year.

Mr. MICHEL. But the point is when there was pressure on you you could come down a certain amount. Now we say there is that much more pressure on us because we have all these other departments to contend with.

Mr. KELLY. But let me just make this point: I would hope you would approve this budget as we submitted it. But if you decide not to approve it as we submitted it, I would hope you would do what we did, that you would make selections and determine what the relative priorities are. It seems to me you make a farce of the budget situation when you do something across the board. This assumes that all services have an equal standing. You would be saying there

are crippled children that should not be served or 5 percent should not be served.

Mr. MICHEL. Your point is well made but by the same token have we not exercised this in the whole budgetmaking process, where we are told we are short this many doctors, we are short this many nurses, we are short this many teachers. There is nothing we are not short of if we are looking at the optimum. There are these relative degrees of where you can put your emphasis and I think your point is well made. We have to operate under priorities in my office, but we have some serious problems before this subcommittee this year and we have to lay some groundwork, I think, to fairly come up with what is right for the moment.

POSITIONS IN DEPARTMENT

Did I hear, in response to one of the questions of the chairman, the figure of a total employment in the Department of around 101,000?

Mr. KELLY. 100,000 is the authorized.

Mr. MICHEL. On a man-year basis?

Mr. KELLY. The authorized number of positions this year is about 105,000 and the man-years are about 100,000 that we expect to pay for.

Mr. MICHEL. And the request this year over last year is how much?

Mr. KELLY. We are asking for a total of 109,700, just a little bit more than 4,700 in excess of this year. This is workload related such as in social security, and so forth.

BROCHURE DISTRIBUTION

Mr. MICHEL. Mr. Secretary, last year we had a discussion on the distribution of education and health program brochures to some 30,000 barber shops. At that time one of the things that came to our attention was that it looked pretty much like a political handout, a propaganda piece. Do you have an increase this year for printing costs of brochures and publications?

Mr. KELLY. I do not think I could specifically answer that question. But I would assume that our printing estimate is higher. It would be hard to distinguish between brochures and regulations and reports that are involved in our printing bill.

Secretary GARDNER. Let me say right off the bat that in the period since then there has been nothing remotely resembling this brochure. We do not want to get into anything that even appears to be subject to the kind of criticism that you are talking about. We did have a tremendous load of printing in connection with the medicare program. We had to get out a lot of information rapidly.

CIA FUNDING

Mr. MICHEL. Did the Department of Health, Education, and Welfare have any knowledge or discussion with the CIA concerning its funding of some of the organizations that they have subsidized or funded?

Secretary GARDNER. Yes, sir. The President appointed me a member of a three-man committee to resolve this situation and to come up with recommendations. We will be coming forward with those recommendations very shortly.

DISTRIBUTION OF PUBLICATIONS

Mr. FLOOD. Will the gentleman yield to me on the question of printing costs?

Mr. MICHEL. Yes.

Mr. FLOOD. I just happen to have here a bundle of this publication. Can somebody tell me why your office is sending us 25 copies of your dollar a copy monthly publication? We get 25 copies. The full Committee on Appropriations has 51 members and this subcommittee has eight members. More to the point, neither this subcommittee nor anybody connected with it asked for these copies and we cannot guess where we could use 25. Of course this does not represent a great deal of money but is this indicative of your distribution of these pamphlets or brochures? We did not ask for these and why 25?

Mr. KELLY. I do not know. I will be glad to check it. The extra copies, of course, only come to you when you sign for them indicating you want to stay on that particular mailing list. That is required every year.

Mr. FLOOD. Did we sign a form? I certainly did not. Did you?

Mr. MOYER. No.

Mr. FLOOD. It is no murder case.

Mr. MICHEL. I think it is a good point. On the Agriculture Subcommittee I usually ask them to send me one copy so I have some idea what they are putting out, and if we need more we will ask for them.

Mr. COHEN. What I think probably happened, the substantive legislative committees have general instructions that whatever things we get out they get copies for every member of the committee. It may be they assumed that the Appropriations Subcommittee wanted us to do that.

Mr. FLOOD. Why don't you just send one for the subcommittee and if anybody wants it they can get it right here.

Mr. SMITH. I think whatever is published, we should get some of them.

Mr. FLOOD. All right, if you want one, send him one; the man is asking for it; but just send one copy to the subcommittee and I think that will take care of us.

ANTI-INFLATION PROGRAM

Mr. MICHEL. In your discussion here of the President's program to combat inflation, I trust that what you set out in these prepared memorandums are all the proposed reductions of the President?

Mr. KELLY. The only thing not accounted for here related to the pay increase and we handle that in connection with the absorption of part of the pay increase and decrease the supplemental proportionately.

MEASUREMENT OF PRODUCTIVITY IN HEW

Mr. MICHEL. Looking back at page 817 of last year's hearings, I think we also had a little colloquy, Mr. Secretary, on the success or failure of your evaluation measurements for personnel. Are there any figures you could cite which would show any increase in productivity of personnel since the institution of this system?

Mr. KELLY. The most measured productivity we have is in the administration of the social security program.

Mr. MICHEL. That is one we always cite as being one of the best administered programs, I think, in Government, but since HEW is in a myriad of other fields we cannot always be saying social security is doing a tremendous job and winking at the other areas.

Mr. KELLY. In the chart presentation I indicated we were only spending $85 million on the administration of all the grant programs in the Department, and I felt there was some concern with respect to this as to whether or not the staff was sufficient to fully give us the kind of managerial accountability we should have. When you have this kind of a grant program you can make the staff very small. Here we are concerned that we do not have adequate staff to give us full accountability. But we have budgeted on a prediction that we can continue to make a 3 percent increase in productivity. I think there are few managerial operations that would predict they could continue to make the same improvements in the future as in the past.

Secretary GARDNER. I would like to comment on that. In my opinion we have a long way to go in putting modern management into all our agencies. The very good reason we cite social security is that it is the one that has instituted what I would call first-class management practices. We are setting up a management consulting office in the office of the Assistant Secretary for Administration. We will be able to go into any agency and help them develop modern reporting methods that will enable us to know what their productivity is. We are revising the whole management setup in the Office of Education. Dr. Goddard has been putting the Food and Drug Administration under improved management.

Mr. MICHEL. I am glad to hear you say that. I took encouragement from the layout of your organizational chart. Sometimes you have to start from scratch.

REGIONAL OFFICES

We, of course, particularly some of us, have been making a point that turning to Washington for the solution of all our problems was creating a bigger and more monolithic giant here. I notice in your testimony quite a bit having to do with the setup of regional offices and giving them more authority and autonomy. Are we not in effect saying we are transferring more of the Federal Government from Washington into regional offices? Does it still suggest that Federal people are better able to guide these programs than the local people?

Secretary GARDNER. The strengthening of the regional offices does not involve the question of Federal versus State power. We are determined, first, not to have Federal domination; and secondly, to have the regional offices where they are needed. The Federal Government cannot coordinate a program for a local area such as a city. If we precooked the program in Washington we would be imposing on the local government. But we can have people on the ground who can answer their questions and make decisions. If there is a group of people sitting around trying to decide how they will improve education and public health and welfare in St. Louis, they cannot do it if the Federal representatives are just guys who have to get up every few minutes and phone Washington.

Mr. MICHEL. Will these regional offices be such that we are shortening the route or the time factor in getting a bona fide request or grant or application approved?

Secretary GARDNER. That is the intention. It takes a lot of courage to say it will happen, but that is what we want to do. And may I say that a much more relevant thing with reference to State control is a move such as we made in this partnership for health legislation where we throw back to the State an opportunity to sort out its own health needs. We give them a block grant and let them do the planning.

COORDINATION OF FEDERAL PROGRAMS

Mr. MICHEL. Going back to your organizational chart I am reminded of a project back home, the Galena Park Home for the Aged. There has been a problem of working with several agencies, but I think what we will end up with is a grant to help coordinate.

That makes me ask the question: Are we getting ourselves so involved that we have to have this mechanism just for the specific purpose of coordination if there is more than one Federal agency involved? Is it that bad?

Secretary GARDNER. I think there is more in the works on effective coordination of Federal programs than I have seen in 20 years. In the last 6 months we have been doing more. Jim Kelly is making studies, the Budget Bureau is making studies. We have worked in a dozen ways which I will not go into now. But I would be happy to put in the record things we have done and will do to simplify this.

Mr. MICHEL. Why don't you set it out in the record so that a year from now we can look at it and see if we made some progress.

(The information follows:)

The Department, independently or in cooperation with other Federal agencies, has acted to improve coordination of activities in many areas of Department concern. Some examples of these efforts are as follows:

In the general area of grants administration

1. A work sharing relationship has been established with the Department of Defense and the National Science Foundation to provide that an indirect cost rate negotiated with a grantee institution on the part of one will be used by the other Federal agencies. The Department is a member of an interagency committee considering establishment of this principle on a Government-wide basis.

2. Comprehensive guidelines for implementing the statutory requirement for cost sharing on research grants (including provision for institutional cost sharing plans) have been developed by the Department. We are cooperating with the Bureau of the Budget and the Office of Science and Technology in the development of improved Government-wide guidelines.

3. In conjunction with other Federal agencies and the Bureau of the Budget, the Department has been developing a set of cost principles for application to grants and contracts awarded to State and local units of Government.

4. Together with other Federal agencies, the Department is working to establish consistent fiscal and administrative procedures throughout the Federal Government for construction grant and loan programs. To accomplish this purpose, a standing Department committee has been created.

5. In the area of time and effort reporting, the Department has developed and made available to the Bureau of the Budget and the Office of Science and Technology a brochure with explicit guidelines for compliance after reviewing the practices of other Federal agencies.

6. The Secretary has appointed a Grant Administration Advisory Committee composed of State, institutional and Federal representatives. The Committee will concern itself with the improved management of extramural programs by institutions and by the Government. It is intended that the committee will foster a continuing constructive dialogue between the Department and is grantee institutions. It will supplement and facilitate existing relationships with grantee institutions rather than substitute or replace such relationships.

7. In cooperation with the Bureau of the Budget and other Federal agencies, the Department has been considering problems relating to computer costing with a view toward arriving at a consistent approach which would encourage and facilitate greater use of computers in the educational process.

8. For internal use, the Department has developed a standard and simplified expenditure report for research grants. It will be made available to the Bureau of the Budget for its use in developing Government-wide procedures in this area.

In special program areas

1. *Model Cities and the Center for Community Planning:* HEW is cooperating with the Department of Housing and Urban Development and other Federal agencies in the development of effective plans for carrying out the Model Cities program. This program is designed to provide assistance and information to the States and communities on the types of Federal aid available, their applicability to individual cities, and procedures to be followed in applying for assistance.

The focus of the model cities program in the Department will be through the recently established Center for Community Planning. The Center is expected to develop a comprehensive HEW position in relation to the model cities program and relate HEW programs to model cities projects both in the planning and execution phases. It will expedite HEW processing of projects falling within the Model Cities programs, provide consultation and technical assistance to States and communities, review applications and, in general, coordinate HEW involvement in this program.

Of a more long-range nature is the Center's function to develop Department goals for the provision of services to communities and to coordinate the efforts of the HEW operating agencies in the achievement of these goals.

2. *Improved Federal-State relationships through regional offices:* The Secretary has directed agencies to strengthen field operations with a view to improving coordination and exchange of information with other agencies of the Department and the Federal Government and with State, local and private organizations. The central responsibility for intergovernmental relations has been placed with the Office of Field Coordination. Regional Directors, with the cooperation of agency staffs, are emphasizing development of closer relationships with State and local agencies. During the past several months, meetings have been held with some 45 Governors. In January a Seminar on Intergovernmental Relations was held with representatives of national organizations of State, city and county governments and similar sessions in this vein are planned for the coming year. Decentralization of decision-making is in process with a view to the regional establishment assuming a major role in the conduct of negotiations and the processing of plans and grants.

3. *Federal Interagency Committee on Education:* This committee, under the chairmanship of the Assistant Secretary for Education, is beginning to provide a coordinating function in planning for educational services for all agencies of the Federal Government. Through joint effort major educational problems are being identified and examined in order that a more coordinated approach to program planning and implementation can be accelerated.

4. *Manpower training:* The Department, as a member of the President's Committee on Manpower (chaired by the Secretary of HEW), is developing methods of optimal local, State-Federal manpower coordination. A Comprehensive Area Manpower Planning System has been developed through the efforts of HEW, Department of Labor and other agencies. This system is producing an interchange of knowledge between the various manpower training programs resulting in a more nearly total service for the individual client. Regional offices are playing a major role in the implementation of the system.

In the area of health manpower, through the cooperative efforts of the Department, Office of Economic Opportunity, Labor and the Veterans Administration, health manpower production expectation has nearly doubled for the coming year.

5. *Partnership for Health legislation:* The passage of this legislation by the 89th Congress represented a major step to strengthen the Federal-State-local health structure. It will enable States and communities to approach their own health needs more rationally, to set their own priorities, and to devise new patterns for the delivery of health services.

Recipients of Federal financial assistance will be given flexibility to prepare and implement plans that accurately reflect the needs of the States and communities. This will permit optimum utilization of resources and avoid the rigidity imposed by the current system of categorical formula and project grants. The Partnership for Health legislation provides for the funding of State and area-wide health planning, continuing aid to State public health activities and project grants to State and local health agencies and non-profit organizations for demonstrating new techniques for the provision of health services and training. Nine regional Health Advisory Review Committees are being established to advise the Regional Health Director and to recommend approval or disapproval of project grant proposals.

6. *Mental retardation:* The Department, through the Secretary's Committee on Mental Retardation, is coordinating the HEW services which are offered to States, individuals and institutions. It is cooperating with the Department of Defense in the program which provides assistance to mentally retarded dependents of active duty members of the uniformed services. The Secretary's Committee serves as the Department's focal point for contact with the newly established President's Committee on Mental Retardation.

7. *Other areas:* Highlights of other significant areas of coordination efforts by this Department are as follows:

Cooperating with OEO in the Child and Parent Center program administered by OEO.

Cooperating with OEO and HUD in attempting to solve the serious health problems of the poor.

Cooperating with OEO in Project FIND, a project similar to Medicare Alert, to use older people in locating the indigent elderly in need of public service.

In programs for the aging, the Department primarily through the Administration on Aging, participated in the White House Task Force evaluating the most pressing current needs of older Americans which resulted in the President's message to Congress on Aid for the Aged.

Cooperating with Department of Agriculture to develop more effective programs to reduce the hazards which may be present in the use of pesticides, and to develop programs to bring comprehensive health services to people in rural areas.

Collaborating with the Veterans Administration and the medical services of the Armed Forces on a multitude of medical research and training programs which are of mutual interest.

Working with Department of Justice to implement the new program for rehabilitation of narcotics addicts.

It should be noted that the above information sets out examples of significant activities and is not intended to be fully representative of the Department's efforts in the direction of improved coordination.

PLANNING, PROGRAMING, AND BUDGETING SYSTEM

Mr. MICHEL. If all the 50 State departments of education were to adopt the same kind of planning, programing, and budgeting system, from the standpoint of the mechanics of the thing would it not be easier for uniformity to be established with regard to policy and decisionmaking throughout the entire Nation?

Secretary GARDNER. I think it might conceivably be easier but I happen to think, at this stage, that we are in such an experimental stage in our planning, programing, and budgeting that it would be far better for the States to pursue their experimentation without trying to achieve much compatibility in this regard. Mr. Kelly may not agree with that.

Mr. KELLY. I think one of the things planning, programing, and budgeting will do for our activities is to help the decisionmakers make informed choices. We will produce information jointly with States so that States can make an evaluation in applying analyses to their localities, not doing it on a national basis but on a State and local basis. I think it offers a great deal of promise.

COMMISSIONER OF EDUCATION LETTER TO STATE SCHOOL SUPERINTENDENTS

Mr. MICHEL. David Lawrence, in Saturday's Washington Evening Star, reports that a circular letter has been sent to State school superintendents informing them that—

At least two Negro teachers must be assigned to predominantly white schools and two white teachers to schools where Negroes are in the majority.

He adds that the objective is to try to achieve racial balance and each year thereafter the quota will be increased.

Has such a circular gone out of HEW?

Secretary GARDNER. Could somebody check with Howe? I do not know if the letter has gone out. I know this has been discussed. This is a very serious problem, as you know. This is the most difficult part of desegregation in the schools and it has been a problem every inch of the way. We have set far less rigorous standards than many of the civil rights people would wish us to set.

Mr. MICHEL. Take my home community, does that mean if we have enough Negro teachers in Peoria we should put two in each of the white schools?

Mr. KELLY. I think this only applies to those organizations that have separate school systems and are now trying to bring about an integrated school system. This is a measure of the extent to which they have dismantled the two school systems.

Mr. MICHEL. We have always said we have not had two school systems at home but some people say we do. In our grade school system at home there is a movement afoot, because it is white with only nine Negroes, to take two adjoining schools with over 50 percent Negroes and combine all three to make sure there is a balance, but, oddly enough, the white students then will be in the minority. It is not too much a stretch of the imagination when you say two systems and we say one, but somebody says, "No, you have two systems." Having read this article I thought we might as well kick it around a little bit.

Secretary GARDNER. Let me say the whole record of court action on this does focus on dual systems, meaning systems which are created by officials acts to serve two different races. This is why it is very difficult to apply title VI in the North because in order to bring a matter to hearing you have to demonstrate that there were racially motivated decisions by officials that resulted in those patterns. That takes a great deal of evidence.

RACIAL BALANCE

Mr. MICHEL. Is it your opinion, Mr. Secretary, that racial balance is an objective or goal to be reached by way of implementing the civil rights acts that we have put on the books in the last few years?

Secretary GARDNER. I am not sure what "racial balance" means. I find it very difficult to judge these things apart from the measures you take to carry them out. I believe, for example, in connection with northern de facto desegregation, it is desirable to have youngsters of both races educated in a normal relationship. I do not think it is good for the Nation or good for the cities to create two absolutely distinct divisions and have the heart of the city Negro and the suburbs white. But you cannot tell people where to live and you cannot go beyond certain lengths in the measures that you take to ask local communities to undertake a restructuring of their own community where the structure is determined by the people's own decisions.

Mr. MICHEL. I think I know by your past statements and your record and your statements before this committee that you are not a man to be easily satisfied with the status quo, that you always want to see a community and the country grow and improve. Let us take a group of students who have been accustomed to a particular level of education in any given school. To achieve possibly this racial

balance, whatever it is, the social planners feel for the overall good of that community we have to mix up the schools to such an extent that it appears there is no conceivable way for those students in a good school to get anything but an inferior education against the standards set before mixing took place. How many young people have to sacrifice their particular quality of education to achieve "racial balance"? I say when we have a problem in an area and somebody is getting second best, let us bring him up to first, that is an obligation of ours. But I cannot for the life of me see taking from somebody to give to somebody else. When it comes to tearing somebody down to build somebody else up, it goes against my grain.

Secretary GARDNER. I certainly understand the point that you are making and understand it very well. We do not have enough data to know what the consequences are. But we have one very important study that has been done, the Coleman report, based on tens of thousands of cases, which indicate that the good students, that is the students from good backgrounds, do not suffer from going to school with youngsters from disadvantaged backgrounds. The youngsters from disadvantaged backgrounds gain and those from good backgrounds do not suffer.

Mr. MICHEL. We have 20 kids in an accelerated class. How can you take somebody who is graded two or three classes lower and put them in the same class? It obviously takes time and effort and everything else away from those who have made the greatest progress in class. I do not see how it can possibly be done. I do not know how they arrive at these conclusions. I will grant you in this world we live in, that there are 12 or whatever percentage of colored persons in the community. My boys are playing football and some are Negroes and it is a good team. I cannot get, though, how we can get this thing resolved without tearing down somebody's quality of education.

Secretary GARDNER. I think it comes down to how you do it. I think there are ways you can do it that would be good and ways that would be bad. I think if you took youngsters who were three or four grades behind your kids and put them in the same class with them it would create an undesirable situation.

Mr. CARDWELL. Mr. Chairman, Commissioner Howe says it is true he released a memorandum to certain chief State school officers. According to Mr. Howe, the memorandum has been described inaccurately by the press. There was a UPI release. The memorandum did attempt to describe to the chief school officers guidelines that the Office of Education would use in appraising school desegregation. Generally it said that the rule of measurement they would use in 1967 for desegregation of teachers would be equal to the number of schools in the district: 15 schools, 15 teachers. By 1968 a doubling of that would be looked upon as reasonable progress. The Commissioner suggested we put the memorandum in the record.

Mr. MICHEL. If that is agreeable, Mr. Chairman.

Mr. FLOOD. Without objection it will be placed in the record at this point.

(The memorandum follows:)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
OFFICE OF EDUCATION,
Washington, D.C., February 8, 1967.

(Identical Letter to Chief State School Officers in 11 Deep South States—Ala., Ark., Ga., Fla., La., Miss., N.C., S.C., Tenn., Tex., and Va. Asst. Comr. Seeley sent letter to Okla. and Missouri)

Hon. ERNEST STONE,
State Superintendent of Education,
State Department of Education,
Montgomery, Ala.

DEAR SUPERINTENDENT STONE: I am attaching copies of a memorandum directed to local superintendents operating under free choice plans concerning procedures for review of their plans.

We would be happy to send copies of this memorandum and the bulletin on summer programs directly to the school districts operating under such plans, unless you would prefer to mail them from your office.

Please let us know at your earliest convenience the procedure you prefer.

Sincerely yours,

HAROLD HOWE II,
U.S. Commissioner of Education.

Attachments (3).

Only three States asked for the material to mail from the State Dept.—Florida, Georgia, and Tennessee.

The Commissioner's memorandum was mailed to the local superintendents in the other States operating under free choice plans.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
OFFICE OF EDUCATION,
Washington, D.C., February 1967.

MEMORANDUM FOR SCHOOL DISTRICTS OPERATING UNDER FREE CHOICE DESEGREGATION PLANS

We believe it will help school districts this year if they are more fully informed of the procedures the Office of Education will use in reviewing the operation of "free choice" desegregation plans.

General Procedure

Each school district with a plan is required to file with the Office of Education by April 15 a report of its anticipated staff and student assignments for next fall. School districts using free choice plans should file the report of their anticipated student assignments within 15 days of the end of the choice period. As soon as we receive the report we will make a preliminary determination of the probable compliance status of the district.

Generally speaking those districts operating under free choice plans which meet the criteria set out below will reveive a letter indicating that on the basis of the progress reported they appear to be in compliance with the Act and will require no further review this year. If we later receive information indicating less progress than anticipated or other compliance problems, then a review which looks at all aspects of the desegregation plan may be necessary.

Criteria for Exemption from Review on the Basis of Spring Reports:

Student Desegregation:

For progress in student desegregation beyond what has been achieved in 1966–67, the criteria for preliminary review are those already set out in Section 181.54 of the guidelines.

It should be noted that the guidelines percentages apply only in cases where there is a "sizeable percentage of Negro students." In many districts with a small percentage (e.g., less than 15%–20%) of Negro students more substantial progress in eliminating the dual system than that indicated in Section 181.54 would be expected.

Staff Desegregation:

Last year school districts requesting a rough guide to expected progress were told that the equivalent of one classroom teacher assigned on a desegregated basis in each school normally would be adequate evidence of a sufficient start on staff desegregation, so that no review would be required. For the coming school

year double that degree of progress and staff desegregation in both formerly white and Negro schools would be expected to assure that a plan is operating effectively. It should be recognized, again, that this can only be a very rough measure. For instance, in districts with a few large schools more progress would be expected, and in districts with a great many small schools less might be expected.

Other Factors:

Other factors that will be considered in making preliminary reviews include: existence of complaints affecting free operation of the plan, existence of small, inadequate segregated schools and other evidence of unequal programs, evidence of building progrems which would perpetuate the dual system, and discriminatory transfers in or out of the districts. Factors which might indicate adequate progress despite failure to meet the student and staff criteria above might include such consideration as the special difficulties presented in school districts where there is a very high percentage of Negro enrollment in the schools (such as 70% or 80% or more).

Districts Requiring Review:

Districts which do not meet the above criteria on the basis of their April 15 reports will be considered to require further review because of probable compliance problems. These will be divided into two groups: (a) those districts whose performance falls substantially below the criteria listed above and (b) those districts coming closer to the above criteria but still requiring review.

Each district in these two groups will be notified of its status, and those in category (a) above will be visited for a review on a priority basis. Districts in category (b) will not be visited immediately and should review their own plans carefully and take every possible step to improve their progress before school opens in the fall. Review of these districts is likely to fall during the school year, and adjustments to achieve compliance are always more of a problem while school is in session.

Summer Programs

In addition to the operation of their regular desegregation plans, school districts should be alert to the requirement that their special summer programs cannot be operated on a segregated basis. State officials have responsibility for reviewing carefully the proposals for these programs to make certain that ineligible projects are not approved. A bulletin about the requirements for summer programs is attached.

HAROLD HOWE II,
U.S. Commissioner of Education.

Attachment.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
OFFICE OF EDUCATION,
Washington, D.C., February 8, 1967.

Memorandum for chief State school officers.

Subject: Civil rights compliance in summer programs operated under title I of the Elementary and Secondary Education Act of 1965, as amended.

I want to remind you that procedures instituted in 1966 governing civil rights compliance in Title I summer programs remain in effect for projects undertaken by local educational agencies in the summer of 1967. The revised Title VI desegregation guidelines, issued on January 1, 1967, repeat the 1966 provision (§ 181.14(b)(4)):

"All special educational programs, such as preschool, summer school and adult education, and any educational program newly instituted, must be conducted without segregation or any other form of discrimination. Free choice desegregation procedures normally may not be applied to such programs."

More detailed explanations of the responsibilities of State agencies for enforcing this provision are contained in my memoranda of April 25, 1966, and July 1, 1966, on this topic. I urge you to review these documents, as they clearly spell out your respsonbilities for assuring that summer programs are operated in a totally desegregated fashion.

The Office of Education attaches great importance to the effective implementation of these procedures. I hope you will remind the local educational agencies in your State of these requirements. In reviewing and approving applications for summer projects, you are requested to review thoroughly with the applicant the procedures that it will follow to assure that the program will be fully desegregated. If projects have already been approved, they should be reviewed again to assure that this requirement is being met. We hope that a careful review at this time

will help avoid the necessity of discontinuing or restructuring a project after it has begun.

Title I staff will visit selected State agencies this spring to review with State Title I Coordinators the procedures your agency is following. In the meantime, I hope you will call upon us if we can be of assistance in clarifying any relevant matters.

HAROLD HOWE II,
U.S. Commissioner of Education.

cc: Regional Assistant Commissioner.

ENTITLEMENT UNDER TITLE I

Mr. MICHEL. On education, last year on July 1 the States were notified they would be operating under the continuing resolution of Congress until such time as the legislation extending the life of the section of the act was passed, and in the President's education message this year he asked the Congress to speed its deliberations in education in order to permit the school officials to plan ahead. Last October the supplemental bill for elementary and secondary school education was signed into law. Why did the States have to wait until almost March of this year to know their entitlement under title I?

Mr. KELLY. It is a very troublesome problem. We were able to tell the States that their aggregate amount would be close to 85 percent of the amount allocated to them last year. But the legislation was not only late in being enacted and the resultant appropriations late, but the law modified the formula for distribution. It required that we get two pieces of data, and until we had them for every school district in the United States we could not make the distribution for the Nation.

Mr. MICHEL. In other words, we passed it on October 27 and—

Mr. KELLY. And we had to find out what the actual expenditures were for the preceding fiscal year. Twenty thousand school districts had to give that information to us. Secondly, rather than using the statistics on aid for dependent children in 1962, we had to update it for 1965. That meant we had to make a census throughout the United States and until all of the information was in we could not make the allocation.

Mr. MICHEL. If we had not changed the formula——

Mr. KELLY. We would have had the money ready for distribution the day the President signed the law.

Mr. MICHEL. You really would?

Mr. KELLY. Yes; and we should have. The system has to come out so that the data that we use is not so current that you have to delay the process in order to make the final distribution.

Mr. MICHEL. I think the point is well made here. What we would like to have is the assurance that if we do not tamper with the formula you are well enough geared up to act with no more than a reasonable delay.

TEACHER-STUDENT RATIO

Mr. Secretary, what improvements have occurred in teacher-student ratio under title I? Do you have any figures on that?

Secretary GARDNER. I doubt we have any figures.

Mr. MICHEL. Do you have any type of information?

Mr. CARDWELL. We have some information that we will submit for the record with the chairman's permission.

Mr. FLOOD. Without objection it will be made a part of the record at this point.

(The information follows:)

PUPIL-TEACHER RATIO

In FY 1966 an additional 380,000 staff members were added to school systems through Title I of which 200,000 were teacher positions. Although there are no specific figures relating the exact decrease of the pupil-teacher ratio it is known that more individualized instruction was a major factor in the Title I program. The use of the 70,000 teacher aides and 66,000 other non-professionals permitted the experienced teacher to spend more time with each child. The Annual Evaluation Report of Title I reveals that reduction of class size was a common approach to meet the objectives of increasing academic achievement and developing communication skills. An example of the effort in reducing class size can be seen in San Francisco:

	Pupil-teacher ratios	
	City standard	Title I schools
Grade 1 (all classrooms)	27:1	22:1
Grades 2 and 3 (all classrooms)	31:1	27:1
Grades 4, 5, and 6	(1)	(1)
Junior high schools	25=1 to 27:1	2 15:1
Senior high schools	25=1 to 27:1	2 18:1

1 In grades 4, 5, and 6 reduction is accomplished by removing selected children from regular self-contained classrooms for small special classes to meet their special needs. These children are usually served on a 45-minute schedule basis. Although no precise full-time ratios can be established because of irregular presence in the classroom, the overall class size reduction is significant.

2 These ratios apply only to the special compensatory education classes conducted in eligible secondary schools.

ADULT BASIC EDUCATION PROGRAM

Mr. MICHEL. Will there be a followup on the adult basic education program to determine the change in employability due to the program?

Secretary GARDNER. We already have some information on that. These people do have considerable success in getting jobs and holding them.

Mr. KELLY. One of the recommendations of the Coleman study was to improve the data collection so that there would be continuing statistics for the evaluation of that program.

TEACHERS CORPS

Mr. MICHEL. Now if I might, Mr. Secretary, let me touch on our Teachers Corps. How many, to use your words, "talented concerned teachers to work in poverty areas" does the Nation need?

Secretary GARDNER. It has never been broken down by poverty areas but there is a shortage and the shortage is increased by the fact that most school districts permit teachers with seniority to have first choice so that experienced teachers leave the tough areas. There is a constant pulling away from the more difficult areas.

Mr. MICHEL. You made a point that it was talked about and that there was a flood of applications. This does not cut too much water with me because I thought the impression around the country was if there was a deficiency the Government would step in and give them an extra teacher. I, in my earlier objections to the Teacher Corps, made the point it was much more oriented toward robbing from existing school districts some of the teaching resources that they needed by using a little added incentive of getting a master's degree or a postgraduate degree. Why not if it will be taken care of by the Federal Government? It was a question as to the motivation, such

as in the Peace Corps program which, incidentally, I supported, though I see there are more recruiting problems now, and the VISTA volunteers. All this free television time has been terrific and still just a few people are taking the carrot. You say we need especially gifted people in this program and I made the point here we were taking people who could not qualify for regular teaching courses and they were being selected for this program. One of my biggest gripes has been some of our teachers get postgraduate degrees and doctor's degrees and do not know what it is to be out teaching kids. The question occurs to me again, would these poverty stricken areas feel slighted if they had teachers in their areas that did not have all the academic background? Would they feel short-changed?

Secretary GARDNER. Would they feel short-changed? No, they would not. Of course the teachers could say, "What do they think they are doing, coming in here where we have been all the time?" But they do not say that. The kids go in where the toughest jobs are. There has been as little irritation in this program as in any program I know of.

Mr. MICHEL. We really have not had set out in the record yet a couple specific instances of what good has been accomplished by one of these persons in a particular school district or area.

Mr. CARDWELL. When Mr. Graham testifies he will cite a number of examples.

Secretary GARDNER. I visited a school district in North Carolina in the mountains 11 miles from the nearest store. Three Teachers Corps fellows were working there under a master teacher. All these fellows were from around that area, they had their roots locally, but they never would have gotten to that township otherwise. The school was a consolidation of eight or nine one-room schools all brought together in one school. These three boys were teaching reading, geography, and doing anything that would help. They worked 4½ days. On Friday afternoon they got off and worked on their master's degree on Saturday and Sunday and drove back Sunday night up to the mountains. You do not normally get that kind of quality.

Mr. MICHEL. Is this criticism due to the fact the Teachers' Union will not give a bonus to those that go to less desirable areas?

Secretary GARDNER. That would involve some work. Even if the Teachers' Union took an enlightened view you still would profit by having a dedicated group of people. I would have more of them. I think to give young people a chance to go out and serve and at the same time learn something is not time wasted. It is time when they are committed to serve the community.

Mr. MICHEL. I was more than a little intrigued by your statement that when the actual Teachers Corps teachers go to the institution where they were getting their master's, that the institutions were geting as much benefit as the students in attaining their degree.

Secretary GARDNER. Mr. Michel, I think you will vote for this.

Mr. MICHEL. I may be talking myself into this.

AVERAGE COST PER INTERN

What is the average cost per intern for the Teachers Corps people?

Secretary GARDNER. I am sorry I cannot answer that.

Mr. CARDWELL. We will train and place on duty this year an average of 1,200 members at a cost of about $17 million. That would include preassignment training, their education for an advanced degree, and

their salaries. It would also include payment for shipment of household effects to their duty assignment and some travel cost as well. We would be glad to give you an average unit cost for each element.

Mr. MICHEL. If you would.

(The information follows:)

Teacher Corps unit costs—Interns entering training, 1966—Annual cost 2-year average

Salaries	$4,187
Training	3,745
Local administration	350
Transportation	198
Total	8,480

INCREASED HOSPITALIZATION COSTS

Mr. MICHEL. Mr. Secretary, in the field of medicine, have hospitalization costs increased this past year?

Secretary GARDNER. They certainly have.

Mr. FLOOD. Will the gentleman yield at that point?

Mr. MICHEL. Yes.

Mr. FLOOD. I have here a story from the Washington Post, "Medical Care Costs Rise at Record Pace." I do not have the date but it is a recent edition and it deals with this subject so I think at this point we will insert that in the record.

(The newspaper article follows:)

MEDICAL CARE COSTS RISE AT RECORD PACE

(By Thomas O'Toole, Washington Post staff writer)

The price Americans pay for medical care is rising at the fastest rate in history.

A medical price study made public yesterday by the Department of Health, Education and Welfare disclosed that physicians' fees went up 7.8 per cent and hospital charges 16.5 per cent last year. Both show every sign of increasing at least at the same rate again this year, the HEW study said. Total dollar statistics were not available for 1966.

The study, which was ordered by President Johnson seven months ago, said last year's increase in hospital charges was the largest yearly raise in 18 years, while the rise in doctors' fees was the biggest annual increase since 1927, the first year a physicians' fee index was kept.

While holding out little hope for an early end to medical price boosts, the HEW made two specific recommendations:

That the Nation develop, demonstrate and evaluate more community health care "systems," to relieve the load on doctors and hospitals.

That the Nation encourage through tax incentive or other means, doctors to form group practices with other doctors, in an effort to lower costs per patient and keep more patients out of hospitals.

What HEW calls the Medical Care Index has risen at double the rate of the Consumer Price Index, the study revealed.

The result of this rise, the HEW said, was that Americans paid out $24.5 billion for medical care in 1964, the last year for which dollar statistics are available. Had the cost of medical care risen at the same rate as other consumer costs, the price to Americans would have been $19.7 billion.

Of the total paid out by Americans for medical care in 1964, about $7 billion went to doctors and $7.35 billion to hospitals, the study shows.

The rise in doctors' fees was blamed largely on the stepped-up demand for their services. "Based on the spending habits of Americans," the study said, "it is estimated that a 10 per cent increase in consumer income results in at least a 3.3 per cent demand increase for physicians' services."

In fact, said the HEW study, the increase in population and per capita income in the last 15 years "added at least 41 per cent to the demand" for doctors' time.

DROP IN FAMILY DOCTORS

At the same time, the supply of doctors has not kept pace with demand, the report said. In the last 15 years, the number of physicians in private practice increased only 14.3 per cent, while the total number of family doctors (pediatricians, internists and general practitioners) declined as more doctors entered specialties.

One result of this "increase in pressure" on the doctors was a raise in fees, the study said. There was no evidence, the study insisted, that the advent of Medicare had played a major role in the fee boosts. "Price indexes for child and adult care," the study said, "moved up more rapidly than five special indexes of surgical and medical procedures particularly applicable to aged persons."

The increase in hospital charges the HEW laid to wage boosts for nurses, hospital technicians and aides.

Between 1960 and 1965, wages and salaries per patient rose 6.4 percent per year—almost exactly the same as the rate of increase in hospital charges.

This rate of increase almost tripled last year, the study showed, as rising wages exerted even more upward pressure on costs. Several nurses' strikes occurred, and many disputes were settled without a strike, which resulted in a rise in nurses' salaries faster in 1966 than in other years.

FORCES AT WORK NOW

The HEW indicated there was no quick way to cure soaring medical costs. If anything, the study said, the same forces that accelerated the rise in costs are harder at work now than they were a year ago.

A separate study showed that total demand for doctors would increase by one third in the next ten years at the same time the number of doctors would grow by only 17 percent.

The same future is in store for hospital charges, the HEW said. "If hospital staff per patient continues to increase at recent rates," the HEW said, "the total wage bill per patient-day seems likely to increase from $27 in 1965 to $38 by 1970."

Not the entire picture was black, said the HEW, which saw several clear rays of hope on the horizon.

One was the recent tendency by doctors to form group medical practices, which tended not only to lower the costs of medical care but to keep many patients out of hospitals by providing more hospital-type service, to the patient away from the hospital.

Between 1958 and 1964, the HEW said, the number of physician partnerships grew by 61 percent and by the end of 1964 about 44,500 doctors (out of 300,000 in the United States) were in 15,300 partnerships and groups across the country.

Mr. MICHEL. Has the increase been 8 or 9 percent this past year?

Mr. COHEN. Our best guess is that it will show about a 12-percent increase on hospital costs.

Mr. MICHEL. Is this this year or last year?

Mr. COHEN. Last year.

Mr. MICHEL. What about this year?

Mr. COHEN. There are two different kinds of figures used. In the testimony before the Ways and Means Committee, where they are having testimony in medicare and medicaid, some of the hospital people have said 15 to 16 percent. I do not think it will be that high in our reimbursement formula for medicare or medicaid, but obviously it is somewhere in that area.

Mr. MICHEL. What does that 10- or 12-percent increase this past year and maybe 15 percent this year all mean to this budget we are talking about here in the field of health and related items?

Mr. COHEN. If it were to continue for the next 3 or 4 years at that rate, for medicare it would require an increase in contribution rates. When Mr. Mills fixed the contribution rates for medicare in 1965, he assumed that medical costs would increase an additional 2.7 percent over the average wage. Wage increases are about 4 percent so that

means that medical costs were expected to increase about 6 or 7 percent a year. There is no question in my mind that part of the increased cost for medicare and the increased cost expected in the future is also due to increased costs in hospital care and physicians' services. The question is how can we bring better efficiency and economy in those areas. That is one of the things we are going to study in this National Center for Health Services Research.

Secretary GARDNER. This is what I consider to be one of the most serious problems we face, these rising costs. One of the problems is that the hospitals are not managed efficiently. They have not developed the techniques and procedures that would permit them to be managed efficiently. And secondly, there is no incentive for lowering costs. I hope you will have an opportunity to take a look at the medical cost study. It is a very good study and we will be pursuing this as far as we can.

COLLEGE COSTS

Mr. MICHEL. What about college costs? How much will they go up?

Secretary GARDNER. I do not thing they are on this kind of a curve. But the problem of financing higher education is an extremely serious one.

Mr. KELLY. I think you should distinguish between the rise in the college costs and the question of what part of that cost is included in tuition. That is really changing who will pay for the increased cost because tuition now is very substantially below cost in almost every instance.

Mr. MICHEL. What is the increase in the cost of higher education and who will bear it and how high can we go before we price ourselves out?

Secretary GARDNER. I think a great deal of it will have to be through public funds. We are still today in many States building extremely expensive educational plants when we should be building for low cost higher education. The junior college, for example, is the kind of thing you can set up with the minimum dormitory cost because the youngsters live in the area and drive to school. The youngsters can get a lot of the services, their board and so on, in the neighborhood. It is doubtful that we can afford the very expensive plants we have built in the past.

INTERNATIONAL EDUCATION

Mr. MICHEL. Last year I asked for the names of those who served on the task force on international education. Last year you gave your name and that of Dean Rusk. Is that so secret that you cannot divulge the other names?

Mr. CARDWELL. The legislation does provide for an Advisory Committee on International Education and the supplemental has $75,000 for that purpose.

Mr. MICHEL. For an Advisory Committee?

Mr. CARDWELL. Yes.

Mr. MICHEL. We do not have one yet?

Mr. KELLY. The funds have not been appropriated.

Mr. MICHEL. Are you thinking of anybody for that Advisory Committee, Mr. Secretary?

Secretary GARDNER. I believe the President has made up his mind on what the makeup will be.

Mr. MICHEL. You are not free to disclose that? Suppose they are characters we do not have a high regard for?

Secretary GARDNER. The President said, "It would be presumptuous of me to do anything before Congress acts."

Mr. COHEN. We took a little advance action some years ago but now we are very conservative about that.

Mr. MICHEL. I am reading from a letter from a university president and he is making a pitch to me to support the International Education Act Fund. He also observes:

> Of course this budget is less than half the $40 million originally authorized by the Act, that is the $18,950,000, but I understand and accept that this sort of appropriation cannot have a high priority in turbulent times like those we are experiencing today. I think my interest and that of the university is evident to you. I do regret what I feel is the mistaken title of the Act because it is essentially a domestic education measure designed to strengthen the research competence of the programs in international studies in our nation's colleges and universities.

This may in part be an answer to what we were kicking around here earlier.

Secretary GARDNER. That is part of the point.

Mr. MICHEL. I have another letter here from one of my old political science professors from Bradley University, Dr. Loo from China, a very distinguished scholar, and he makes the pitch here particularly for enrichment of studies in the Asia field.

With that I will be glad to yield at this point, Mr. Chairman.

Mr. FLOOD. Mr. Natcher?

SUPPORT OF THE PRESIDENT'S BUDGET

Mr. NATCHER. Mr. Secretary, as you know, in some sections we will have considerable effort to increase a number of amounts in this budget for fiscal year 1968. Is it your intention now to hold the line and have the same apply to your Department heads and Assistant Secretaries in the Department of Health, Education, and Welfare?

Secretary GARDNER. I am afraid I do not understand.

Mr. NATCHER. In support of the budget.

Secretary GARDNER. Yes, sir.

Mr. NATCHER. Your answer is yes?

Secretary GARDNER. Yes, sir.

Mr. NATCHER. As you will recall, last year we had considerable discussion over the increases in this particular bill and you will remember, Mr. Secretary, that the President asked the Appropriations Committee of the House to come down and at that time he discussed in detail some of the amounts that exceeded the budget. You remember that?

So it is your intention, Mr. Secretary, to stick with the amount and the requests that you have presented to the committee?

Secretary GARDNER. It most certainly is.

SUPPLEMENTAL REQUESTS

Mr. NATCHER. Now, Mr. Secretary, let me ask you, do you know of any amounts that have been presented in your budget where a supplemental request will come up later?

Mr. KELLY. No, what we have identified is related to new legislation.

Mr. CARDWELL. We did indicate earlier in our testimony that the supplemental carried in the President's budget for public assistance would be at a higher cost. That has already been done.

Mr. NATCHER. Not considering the matters we know about as far as any other requests are concerned, you have none in addition; is that correct, Mr. Secretary?

Secretary GARDNER. Yes, sir.

FELLOWSHIPS FOR ELEMENTARY AND SECONDARY TEACHERS

Mr. NATCHER. In your statement, Mr. Secretary, you make certain observations concerning the number of fellowships for 1968. I believe you point out that some 14,000 fellowships for elementary and secondary school teachers and 17,000 for future college teachers will be awarded. The question I have in mind is as to whether or not you are cutting down on construction and other matters in the educational program to carry along your scholarship program. Are you doing that, Mr. Secretary?

Secretary GARDNER. No, sir.

Mr. NATCHER. Do you feel we should have this many fellowships that you point out in your statement?

Secretary GARDNER. Yes, sir. We have felt that. In fact we have been under pressure to have a lot more than that, but we have kept it down.

As you know, these are very, very popular programs.

CONTROL OF RESEARCH FUNDS

Mr. NATCHER. Mr. Secretary, further in your statement to the committee, you point out areas of special concern to you and to the members of your Department, one of which of course is research.

Do you feel that at the present time in the Department of Health, Education, and Welfare that you have a little better control over the money that is being spent for research than we have had in the past?

Secretary GARDNER. As I remember, the past point of wavering control has not been in the Department. Is that correct? Has it not been mainly that the Congress has appropriated more funds?

Mr. NATCHER. Mr. Secretary, assuming the Congress in the past has appropriated more maybe than the Department of Health, Education, and Welfare wanted or could use now in administering these funds, have you attempted to see that this money was properly used and not too many overlapping programs and studies were underway at the same time?

Secretary GARDNER. Yes, sir.

Mr. NATCHER. As you know, doctors in this country say a lot of our research money in HEW is squandered. They say you have so much you do not know what to do with it.

Do you feel you have a little better control now over your research money?

Secretary GARDNER. Yes, sir. We have had an extremely careful review of this, as you probably know, by the so-called Woolridge Committee, headed by Dean Woolridge. I would say that is about as distinguished a group of men as we could get for a comparable

review. They came up with a very strong endorsement of most of what NIH has been doing.

It did criticize some of the contract research, and we have moved very strongly to meet the defects that were revealed in the report.

COMPLIANCE WITH CIVIL RIGHTS ACT

Mr. NATCHER. As you know, I am from the State of Kentucky, and Mr. Secretary, I want you to know, as one member on this committee, I do not believe in second-class citizens. I voted for every constitutional civil rights bill that has been presented to the Congress since I have been a Member. Two of them I did not vote for, Mr. Secretary, because as a lawyer I sincerely believed that they were unconstitutional. I believe that all of us, as provided for in the Constitution have our rights and I do not think we should have second-class citizens.

I want to go back with you just a little bit with some matters I discussed with the Commissioner of Education when he appeared before our committee.

By the way, Mr. Secretary, I say this to you in all frankness, your Commissioner of Education is rapidly becoming the most controversial figure in the Federal Government.

As far as compliance is concerned with our Civil Rights Act of 1964 and our Elementary and Secondary Act of 1965, I am in favor, Mr. Secretary, of the law being complied with in detail, to the last word and figure. But I am just wondering what authority the Commissioner of Education has for some of the actions he has recently taken, and one of them was pointed out by Mr. Michel, which concerns the recent issue of his directive to the school superintendents and the heads of the school systems in 17 States.

A few minutes ago you made the statement that the courts hold that faculty assignment is a part of doing away with segregated schools.

Mr. Secretary, at this point in the record I would like for you to place any decision from the Supreme Court that holds this.

(The requested citations follow:)

Bradley v. School Board of City of Richmond, 382 U.S. 103 (1965)
Rogers v. Paul, 382 U.S. 198 (1965)

As you well know, under title IV, section 401, of the Civil Rights Act of 1964, Congress defined what segregation did not mean, and I quote directly out of the act: "but desegregation shall not mean the assignment of students to public schools in order to overcome racial imbalance." That is in the law.

What authority, Mr. Secretary, does the Commissioner of Education have to direct that teachers be hired based on race? What is his authority for that?

Secretary GARDNER. I think that the best thing will be for me to submit a full statement for the record.

We believe, and let me say that we base our action on careful examination not only of the legislation and the legislative history, but the court cases which must serve as our guide, and continuous checking with the Attorney General. I would find it impossible to operate on the basis of my own opinions and judgments in this.

It seems to me that I must move at every step in conformity with what the Attorney General and the courts regard as appropriate. I

would be very happy to put into the record a full statement of what we regard as the basis for the faculty desegregation effort.

Mr. NATCHER. And also the directives that the Commissioner of Education has issued to the school superintendents and the authority for his directives that he has issued since the passage and the operation of the Civil Rights Act of 1964, and the Elementary and Secondary Act of 1965.

Secretary GARDNER. Yes.

Mr. NATCHER. Mr. Secretary, I do not know of any provision of the Constitution that grants authority to the Federal Government to tell the public schools what teachers they may select or otherwise to exercise control over the choice of faculty members of an educational institution. I do not know of any decision of the Supreme Court that holds the Federal Government has that authority, and certainly Congress has passed no law to that effect.

This may be a right insignificant matter as far as some people are concerned, but it is not, Mr. Secretary. This involves not only the 17 States that the directive has recently been sent down to, but it involves school systems throughout the United States. And the program was started in such a bombastic fashion that the people in the country have not gotten used to it yet.

I am just wondering, Mr. Secretary, what we will have to do in Congress to see that the Commissioner of Education and the Department of Health, Education, and Welfare operates within the law. I am just wondering what steps we are going to have to take to see that is done.

I say this to you frankly, Mr. Secretary. There are a great many Members of Congress, not only from the border States and in the South, but, as Mr. Michel has pointed out here, from the State of Illinois and other States that are greatly concerned about the actions that the Commissioner of Education is taking at this time.

In this statement that you place in the record, I wish you would go into detail, Mr. Secretary, because I know of no authority for a great many moves that the Commissioner has made and contemplates for the future.

NO CHANGE IN GUIDELINES

The other day when he was here, I asked him about his program and his guidelines for the next year, and he said there would be no change. Does that meet with your approval, Mr. Secretary?

Secretary GARDNER. Yes, sir.

Mr. Natcher, we just reviewed this whole thing before Senator Russell Long's committee, the Senate Finance Committee, about 30 days ago. They went in great detail into the legal background for every move that we have made.

I do believe that I can present to you quite a solid case of the basis for our actions. In fact I believe that we have very little choice in most of these matters based upon what is presented to me as the legal requirements under which we are functioning.

Mr. NATCHER. Mr. Secretary, at that hearing did you cite cases from the Supreme Court or any authority at all? Did you actually cite the cases?

Mr. HUITT. Yes, sir. This has been before the Rules Committee and the Judiciary Committee last fall, as well as before the Finance Committee of the Senate. On Saturday and today the House Education and Labor Committee also went through the same thing in the

record and the cases decided right down the line. I think the Secretary could certainly document this right out of the record.

Mr. NATCHER. With your permission, Mr. Chairman, at this point in the record I would like to have this matter documented in detail, if you would, please.

Mr. FLOOD. It is so ordered.

(The information follows:)

The following letter from the Secretary to Senator Carl Hayden is accompanied by a legal memorandum from the Department's General Counsel supporting the legality of the desegregation guidelines. The memorandum cites Federal court decisions upholding the guidelines and includes references to opinions by the Attorney General. Included also are references to the guideline requirement for faculty desegration and the decisions of Federal courts which have held this to be a justified and necessary part of desegregation plans.

THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE,
Washington, December 30, 1966.

Hon. CARL HAYDEN,
Chairman, Senate Appropriations Committee,
Washington, D.C.

DEAR MR. CHAIRMAN: In the Committee on Appropriations Report No. 1631, dated September 22, 1966, the Committee recommended that I re-examine the 1966 Statement of Policies for School Desegregation to see whether they conformed with the intent of Title VI of the Civil Rights Act of 1964.

I wish to report that the legality of the policies has again been carefully reviewed both by our own General Counsel and the Acting Attorney General. This review has included both the legislative history of the Civil Rights Act of 1964 and the recent decisions of the courts. It is the considered judgment of both these officers that the original legal opinions on the policies continue to be valid and that the policies are legal, fair, reasonable and appropriate to carry out the letter and the spirit of Title VI. I have enclosed a memorandum prepared by our General Counsel which details the legality of those provisions about which questions have most frequently been raised. We have also been advised that the U.S. Court of Appeals for the Fifth Circuit has issued an opinion further validating the legality of the School Guidelines. You may be sure that we will continue to develop our policies consistent with the final rulings of the courts.

Last year we learned that the publication of the school desegregation policies late in the school year placed a heavy burden on school systems. This year, we have therefore determined to make no significant changes in the desegregation policies issued in March 1966 and to distribute them at this time to the schools. Immediate distribution assures that school systems will have the necessary time for appropriate planning which will insure continued progress in this area.

I have also examined and reviewed complaints which go to the manner in which the guidelines have been interpreted and administered by Office of Education staff. I am convinced that most of the complaints originated because of disagreement with the Department's policy rather than because of failure to carry out these policies properly. Nevertheless, I have asked Commissioner Howe to examine with care the instances in which these complaints occurred and to correct administrative procedures where such action is warranted.

Sincerely,

JOHN W. GARDNER, *Secretary.*

MEMORANDUM

To: The Secretary. NOVEMBER 29, 1966.
From: Alanson W. Willcox, General Counsel.
Subject: Review of legal authority for the 1966 school desegregation guidelines.

Pursuant to your recent request, I have reviewed the legal authority for the Revised Statement of Policies for School Desegregation Plans (the Guidelines") and my earlier advice to you concerning the legal authority for it.

I have completed this review, and I unhesitantly reaffirm my advice that the 1966 Guidelines are fully consistent with any supported by title VI of the Civil Rights Act of 1964 and the decisions of Federal courts.

In addition to the analysis of court decisions in my memorandum of March 7, 1966, to Commissioner Howe, the pertinent decisions are discussed in a state-

ment entitled "Authority for the 1966 School Desegregation Guidelines." That statement served as an attachment to a letter of May 24, 1966, from Commissioner Howe to Senator Fulbright. More recently the Courts of Appeals for the Fourth and Fifth Circuits have handed down decisions in *Wheeler* v. *Durham City Board of Education* (No. 10,460, C.A. 4th, July 5, 1966) and *Davis* v. *Board of School Commissioners of Mobile County* (No. 22,759, C.A. 5th, August 16, 1966). These reaffirm principles upon which the Guidelines are based, particularly the fact that teacher desegregation is an essential part of the desegregation plans. Further, in the *Mobile* case, the Court pointed out as one of the principal legal defects in the plan there under review "the fact that even as to those grades which, under the plan, have actually become 'desegregated' there is no true substance in the alleged desegregation. Less than two-tenths of one per cent of the Negro children in the system are attending white schools."

The Deputy Attorney General recently submitted to Congressman Howard W. Smith, Chairman of the House Rules Committee, a letter requested by him regarding faculty desegregation. The Chairman had asked whether this Department has authority, under title VI of the Civil Rights Act of 1964, to require a school district maintaining a dual school system to desegregate its faculty as a necessary part of desegregating its school system. The Department of Justice responded with a letter dated October 4, 1966, and an attachment citing numerous judicial decisions in which the courts had required school districts, as a part of school desegregation plans, to cease hiring and assigning faculty on the basis of race and in many cases to assign teachers for the express purpose of overcoming the effects of past discrimination. The letter concluded with the following sentence: "For the foregoing reasons we conclude that section 601 [of the Civil Rights Act of 1964] applies to the desegregation of faculty and staff of school systems that have been racially segregated and that section 604 [of the Civil Rights Act of 1964] does not preclude such application."

It should be noted, on the other hand, that the Report of the Senate Committee on Appropriations (pp. 71 and 72, Report No. 1631, 89th Cong., 2d Sess.) questioned whether the Guidelines are consistent with legislative intent on the ground that they allegedly require assignment of pupils in order to overcome racial imbalance. The Committee apparently felt that the definition of "desegregation" in section 401(b) of the Act, and the provision of section 407(a) which provides that "nothing herein shall empower any court or official to require the transportation of students to overcome racial imbalance," were intended to be applicable to actions under title VI and that the Guidelines required action to overcome such imbalance.

We are satisfied that the Guidelines do not require action "to overcome racial imbalance." It should be noted, however, that section 402 specifies that the definitions it contains are "[a]s used in this title" [IV], and also that title VI does not contain the defined word "desegregation" or the word "desegregate." It is therefore difficult to conceive of a court holding that, as a legal matter, the title IV definition is controlling in title VI. Moreover, the context of the quoted language in section 407(a) indicates that it concerns only desegregation actions brought by the Attorney General, and not the refusal or termination of Federal financial assistance under title VI. The Senate Appropriations Committee Report, however, is based upon statements made by Senator Humphrey in response to questions asked by Senator Byrd of West Virginia.

Some time ago my staff prepared a statement showing that an examination of the colloquy in context demonstrates that Senator Humphrey was not referring to requirements applicable to school districts which have been maintaining dual school structures, but only to what would be imposed in *de facto* situations which courts have held not to violate the constitutional rights of students. In fact, Senator Humphrey emphasized that the provision in question simply embodied the substance of *Bell* v. *School City of Gary*, 324 F. 2d 209 (C.A. 7th, (1963), cert. den. 377 U.S. 924). (110 Cong. Rec. 12715–12717, June 4, 1964)

The Guidelines are consistent with Senator Humphrey's explanation because he made clear at that time that the amendment did not prevent action "for the purpose of preventing denial of equal protection of the laws," [i.e., a violation of the children's rights under the Fourteenth Amendment]. (110 Cong. Rec. 12714, June 4, 1964)

The Guidelines do not require more for the continuance of Federal assistance than a plan looking toward the elimination of the dual school system as required by the Fourteenth Amendment. These requirements are discussed in my memorandum of March 7, 1966, and the attachment to Commissioner Howe's letter of May 24, 1966, to Senator Fulbright.

The performance provisions of which the Senate Appropriation Committee report is critical do no more than follow constitutional requirements. They provide that for the school year 1966–67 a school district may comply with title VI through operation of a choice plan under which schools continue to be maintained for Negroes. But if in practice such plans are not making progress toward the elimination of the dual school system, the Commissioner may require that the school officials take further action to make progress or may require a different type of plan such as geographic zoning (45 C.F.R. 181.54). Where a school district assigns children to schools on the basis of non-gerrymandered geographic zoning, the effectiveness test referred to above does not apply.

Obviously, a school system which has adopted a free choice desegregation plan, but which is making little or no progress in the elimination of its dual school system, is not satisfying its constitutional obligation, as defined by the decisions of the Federal courts, to desegregate its schools. Just as obviously, the Commisioner of Education would not be satisfying his obligation under title VI and the Regulation if he were to determine that such a plan is adequate to carry out the purposes of title VI.

The percentages stated in the Guidelines do not provide a rigid rule for the degree of progress required of each school district. They do, however, provide a guide to the Office of Education in determining whether or not a free choice plan should be scheduled for review and a guide to the school district as to what, in general, might be considered reasonable progress. In this same section, there is an indication of what might be done in the event there is a substantial deviation from these expectations.

Any school district which believes it is being asked to do more than the law requires has full recourse to an administrative proceeding and a thirty-day notification to Congressional committees before a termination of Federal assistance (sec. 602, Civil Rights Act of 1964). Moreover, if it believes the termination to exceed the Commissioner's authority under the law, it is entitled to judicial review as provided in section 603.

In short, the decisions of the Federal courts establish that local school officials who have in the past maintained separate schools for Negro and white children are under a constitutional compulsion to provide a single desegregated school system for all children. At no time did the Congress intend in title VI or elsewhere in the Civil Rights Act of 1964 that any school child receive less than his full measure of constitutional protection. The responsibility which school officials who are desegregating their school systems voluntarily must assume in order to qualify for Federal assistance may not, if the purposes of title VI are to be carried out, be any less than the responsibilities imposed on school officials by the courts in recent school desegregation decisions. The Guidelines were issued to inform school officials of what those responsibilities are and are in accord with those decisions. If school systems assuming a lesser degree of responsibility were permitted to receive Federal assistance, the purposes of title VI would be thwarted.

The next entry is a memorandum from the General Counsel to the Commissioner of Education discussing the legality of the guideline's test for performance. Support for the legality rests upon the HEW regulations implementing title VI of Civil Rights Act of 1964 (45 C.F.R. pt. 80) and a series of Federal court decisions, including cases heard in the Fourth, Fifth, Sixth, and Eighth Circuit Courts.

MEMORANDUM

MARCH 7, 1966.

To: Harold Howe II, Commissioner of Education.
From: Alanson W. Willcox, General Counsel.
Subject: Title VI—Civil Rights Act—Revised statement of policies for desegregation plans—Test for performance.

This relates to your request for my opinion on the validity of a test of effectiveness to determine the need for a change in a school system's freedom of choice desegregation plan. The test would be based upon the percentage of Negro students who were in fact transferred from segregated schools. The percentage of transfers expected would vary as outlined in the Statement of Policies, dependent upon the rate of transfers in previous years.

"Where there is substantial deviation from these expectations, and the Commissioner concludes, on the basis of the choices actually made and other available evidence, that the plan is not operating fairly, or is not effective to meet constitutional and statutory requirements, he will require the school system to take additional steps to further desegregation.

"Such additional steps may include, for example, reopening of the choice period, additional meetings with parents and civic groups, further arrangements with State or local officials to limit opportunities for intimidation, and other further community preparation. Where schools are still identifiable on the basis of staff composition as intended for students of a particular race, color, or national origin, *such steps must in any such case include substantial further changes in staffing patterns to eliminate such identifiability.*

"If the Commissioner concludes that such steps would be ineffective, or if they fail to remedy the defects in the operation of any free choice plan, he may require the school system to adopt a different type of desegregation plan." (Emphasis added.)

The Commissioner's authority in this area stems from the HEW Regulation to effectuate title VI of the Civil Rights Act of 1964 (45 CFR Part 80). Under section 80.4(a) of that Regulation and pursuant to requirements under section 80.4(b), an assurance of compliance, which has been standardized within the Department as HEW Form 441, as required of each local school system as a condition to the extension of Federal financial assistance.

Section 80.4(c), however, provides an alternative to the provision of such an assurance if the school system submits a final desegregation order of a Federal Court or "a plan for the desegregation of such school or school system which the Commissioner of Education determines is adequate to accomplish the purposes of the Act and this Regulation, and [if the school system] provides reasonable assurance that it will carry out such plan; in any case of continuing Federal financial assistance the Commissioner may reserve the right to redetermine, after such period as may be specified by him, the adequacy of the plan to accomplish the purposes of the Act and this regulation."

Three questions are presented as discussed below.

1. May the Commissioner determine the adequacy of a plan solely on the basis of results achieved as measured by the percentage of students who transfer from segregated schools and without regard to whether the school system acted to prevent transfer?

In the years immediately following the second *Brown* decision[1] there were many assertions that so long as a school system with racially segregated schools did not prevent Negro students from transferring to other schools, the students were not deprived of their Constitutional rights. In short, it was not the maintenance of a dual school sytem, but the prohibition against the Negro students' attending the schools attended by whites which constituted discrimination.[2]

Whether this was ever generally considered good law is immaterial for our purposes here, because clearly it is not the rule followed by the courts today. It now is well recognized that the discriminatory effects of almost a century of compulsory segregation and the many years of involuntary servitude which preceded that, are not overcome by allowing Negro students to attend the formerly all white schools while the school system continues to maintain schools intended for students of a particular race, color, or national origin. In *Singleton* v. *Jackson Municipal Separate School District*, 348 F.2d 729, 730, note 5 (C.A. 5, 1965) the Court stated:

"In retrospect, the second Brown opinion clearly imposes on public school authorities the duty to provide an integrated school system. Judge Parker's well known dictum ('The Constitution, in other words, does not require integration. It merely forbids discrimination.') In *Briggs* v. *Elliott*, E.D.S.C. 1955, 132 F. Supp. 766, 777, should be laid to rest. It is inconsistent with Brown and the latter development of decisional and statutory law in the area of civil rights."

More recently that same Court had occasion to note:[3]

"The Constitution forbids unconstitutional state action in the form of segregated facilities, including segregated public schools. School authorities, therefore, are under the constitutional compulsion of furnishing a single, integrated school system."

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[1] *Brown* v. *Board of Education*, 349 U.S. 294 (1955).

[2] See *Briggs* v. *Elliott*, 132 F. Supp. 776, 777 (E.D., S.C., 1955); *Avery* v. *Wichita Falls Ind. School Dist.*, 241 F. 2d 230 (C.A. 5th, 1957); *cert. den.* 353 U.S. 938 (1957); *Boston* v. *Rippy*, 285 F. 2d 43 (C.A. 5th, 1960).

[3] *Singleton* v. *Jackson Municipal Separate School District*, 355 F. 2d 865. (C.A. 5th, Jan. 26, 1966). The Court did recognize that administrative problems may justify an orderly transition period during which the desegregation may take place, but even so, it held that this transition may not prevent any individual child, even though in a grade not yet reached by the desegregation plan, from exercising his right to transfer.

The concurring portion of an opinion of Judges Sobeloff and Bell in *Bradley* v. *Board of City of Richmond*[4] stating in part:

"Affirmative action means more than telling those who have long been deprived of freedom of educational opportunity, 'You now have a choice.' In many instances the choice will not be meaningful unless the administrators are willing to bestow extra effort and expense to bring the deprived pupils up to the level where they can avail themselves of the choice in fact as well as in theory. A court before approving a plan, must scrutinize it in detail to satisfy itself that the assumptions upon which the plan is predicated are actually present. The district judge must determine whether the means exist for the exercise of a choice that is truly free and not merely pro forma. This may involve considering, for example, the availability of transportation, the opportunity to participate on equal terms in the life of the school after the pupil's arrival, and any other circumstances that may be pertinent."

Other courts also have recognized the obligation of the school system to do more than refrain from interfering with transfers. In *Wright* v. *County School Board of Greensville County*, 352 F. Supp. 378 (E.D., Va.; (January 27, 1966)) the Court stated:

"* * * This circuit has recognized that local authorities should be accorded considerable discretion in charting a route to a constitutionally adequate school system. Freedom of choice plans are not in themselves invalid. They may, however, be invalid because the 'freedom of choice' is illusory. The plan must be tested not only by its provisions, but by the manner in which it operates to provide opportunities for a desegregated education. In this respect operation under the plan may show that the transportation policy or the capacity of the schools severely limits freedom of choice, although provisions concerning these phases are valid on their face."

Similar holdings are contained in: *Dowell* v. *School Board of Oklahoma City, Okla.*, 244 F. Supp. 971 (W.D. Okla., 1965); *Bell* v. *School Board of City of Staunton, Va.*, 349 F. Supp. 249 (W.D. Va., Jan. 5, 1966) and *Kier* v. *School Board of County of Augusta*, 249 F. Supp. 239 (W.D. Va., Jan. 5, 1966).

In *Dove* v. *Parham*, 282 F. 2d 256 (1960), the Court of Appeals for the Eighth Circuit recognized the obligation of a school district "to disestablish a system of imposed segregation".

2. May the Commissioner require in every such case of ineffectiveness that the school system make substantial further changes in staffing patterns of the schools to eliminate identifiability of schools as intended for students of a particular race?

That the identifiability of a school as intended for Negro students is a restriction upon the right of free choice and inconsistent with a valid desegregation plan, can scarcely be denied. Whether a school is so designated by the use of clear words to that effect or whether it is so identified through other indicia including staff assignments, the school system has not met its responsibility to eliminate dual school arrangements, as already described in this memorandum.

"The defendants by the segregation of teachers, continue to maintain three clearly delineated Negro schools. '[T]he presence of all Negro teachers in a school attended solely by Negro pupils is the past denotes that school a "colored school" just as certainly as if the words were printed across its entrance in six-inch letters'. *Brown* v. *County School Board*, 245 F. Supp. 549, 560 (W.D. Va. 1965)" *Kier* v. *School Board of County of Augusta, supra.*

Moreover, for some time cases have indicated that in the consideration of particular plans for desegregation, some involving zoning and other choice, the court should consider the possible effect of "assignment of teachers by race not as seeking to protect rights of such teachers, but as a claim that continued assigning of teaching personnel on a racial basis impairs the students' rights to an education free from any consideration of race." *Mapp* v. *Board of Education, City of Chattanooga, Tenn.*, 319 F. 2d 571, 576 (C.A., 6th 1963); *Northcross* v. *Board of Education, City of Memphis, Tenn.*, 333 F. 2d 661 (C.A. 6th, 1964); *Jackson* v. *School Board, City of Lynchburg, Va.*, 321 F. 2d 230 (C.A. 4th, 1964); *Augustus* v. *Board of Public Instruction, Escambia County, Fla.*, 306 F. 2d 862 (C.A. 5th 1962); *Board of Public Instruction of Duval County, Fla.* v. *Braxton*, 326 F. 2d 616, 620 (C.A. 5th, 1964); *Christmas* v. *Board of Education of Harford County, Maryland*, 231 F. Supp. 331 (D.C., D.Md., 1964); *Dowell* v. *School Board of Oklahoma City, Okla., supra*; *Bell* v. *School Board of City of Staunton,*

[4] 345 F. 2d 310, 323 (C.A. 4th, 1965). Reversed on other grounds, 382 U.S. 103, 15 L. Ed. 2d 187, 86 S. Ct. 224 (1965).

Va., supra; and *Kier* v. *School Board of County of Augusta, supra.* In the Oklahoma City case the court said (at 978):

"* * * where the cessation of assignment and transfer policies based solely on race is insufficient to bring about more than token change in the segregated system, the Board must devise affirmative action reasonably purposed to effectuate the desegregation goal. This not new law."

Recently the Court of Appeals for the Fifth Circuit stated that it is "essential that the plan provide an adequate start toward elimination of race as a basis for the employment and allocation of teachers, administrators and other personnel." *Singleton* v. *Jackson Municipal Separate School District* (Jan. 26, 1966), *supra*, note 3.

In *Bradley* v. *School Board, City of Richmond, supra*, note 4, the United States Supreme Court vacated a lower court's order, saying, "There is no merit to the suggestion that the relation between faculty allocation on an alleged racial basis and the adequacy of the desegregation plans is entirely speculative."

The fact that schools remain identifiable as intended for Negro students because of the staffing pattern and the further fact that there is not effective desegregation in the actual operation of the free choice plan, provide a reasonable justification for the Commissioner to hold that the objectives of title VI and the Regulation cannot be achieved unless the racial identification of the schools is removed.

The importance of prompt steps to wipe out such identification is underscored by the difficulty of having a choice period or of otherwise reassigning children after the school year has commenced. The relatively short period which intervenes between the choice period and the time when final plans should be made for the operation of schools for the coming year, argues for more prompt action than complicated factual evaluations permit. Staff reassignment to remove the identifiability of schools on a racial basis should not be foreclosed even if the school system should assert that other steps might secure results. In fact, if the school system knew of actions which could have been taken to secure better results, it should already have taken them.

It should be recognized that changes required in a plan including those addressed to the removal of the identifiability of schools on a racial basis, would not always substantially affect assignments for the school year for which the poor performance is indicated. The objective of a desegregation plan is the total elimination of the dual school system, however, and the test of performance is significant, not only as measuring what will happen in 1966–7, but also as a gauge of progress toward the final objective. If less than the expected showing is made for the coming school year, there is every reason to insist on steps calculated to speed up the process thereafter, and to set the stage for freer choices for the succeeding school year.

In expressing the foregoing views, I am cognizant that section 604 of the Civil Rights Act of 1964, provides that nothing in title VI "shall be construed to authorize action under this title by any department or agency with respect to any employment practice of any employer. . . ." That section, in my opinion, does not preclude the action referred to above.

Even if we assume that the assignment of teachers by the public school system is an "employment practice", section 604 does not preclude action based upon the need to prevent discrimination against students as beneficiaries of the Federal aid as distinguished from actions taken for the sole purpose of protecting employees as beneficiaries (i.e., their employment being the benefit) from discrimination with respect to practices applied to them.

This is demonstrated by the express language which makes section 604 inapplicable "where a primary objective of the Federal financial assistance is to provide employment." Moreover, the legislative history indicates that the Congressional concern which led to section 604 related to situations where the employment could not be identified with possible discrimination against beneficiaries of the programs receiving Federal financial assistance.[5]

The principal thrust of title VI is to eliminate discrimination against the beneficiaries of Federal financial assistance, other than as employees, as set out in

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[5] Cf. Minority Report in House Report No. 914, p. 69 (88th Cong., 1st Sess.) with 110 Cong. Rec., pp. 6545, 12720, 12714.

section 601. The Civil Rights Act of 1964 is highly remedial legislation.[6] Where provisos and exceptions such as section 604 are susceptible to alternative constructions, they should be read so as to avoid defeating the primary purpose of the Act.[7]

Where, as the decisions cited above indicate, an employment practice operates not only as a discrimination upon the students on the ground of race, color, or national origin but also as a restriction upon their exercise of free choice, section 604 does not limit the Commissioner's authority to act as described above any more than it limits his authority to object to a desegregation plan should a school adopt an employment practice of denying promotions to teachers who fail to discourage Negro students from choosing white schools.

It is, therefore, clear that section 604 does not limit the Commissioner's authority to prevent discrimination against students, even where the discrimination is a result of staff employment practices.

3. If the Commissioner concludes that further steps would be ineffective or fail to remedy the defects in the operation of a free choice plan, may he require that the school system elect a different type of desegregation plan than free choice?

Under section 80.4(c), the Commissioner has a responsibility to require changes in a desegregation plan if he determines that the plan is not adequate to accomplish the purposes of title VI and the Regulation. If he determines that the situation in a given school system is such that a free choice plan will not be adequate he has no option but to require, for continued compliance, a type of plan which he can determine will be adequate.

The final item is an exchange of correspondence between Senator William Fulbright and the Commissioner of Education concerning questions about the desegregation guidelines raised by the Board of Education of Stuttgart, Ark. The Commissioner's letter provides a detailed discussion of legal and administrative questions raised by the guidelines.

UNITED STATES SENATE,
Washington, D.C., April 5, 1966.

HON. HAROLD HOWE, II,
Commissioner of Education,
Department of Health, Education, and Welfare,
Washington, D.C.

DEAR DR. HOWE: Enclosed for your consideration is a letter dated April 1, addressed to me by Mr. Leland Stratton, President of the Board of Education of the Public Schools in Stuttgart, Arkansas. I have received similar letters from the School District in Texarkana, Arkansas, and the Board of Education in Arkansas City, Arkansas. I have also reviewed your revised statement of policies for school desegregation plans and the several auxiliary documents which participating school systems are required to sign, publish, or mail to families of students in the system.

In order that I may respond to these letters, I would appreciate receiving from you: (1) a discussion of the ways in which the new guidelines may be different from the guidelines followed by these school systems in 1965; (2) an explanation of the reasons for and the authority for these changes; and (3) your specific comments upon the numbered assertions contained in the letter addressed to me by Mr. Stratton. Your prompt attention to this request will be appreciated.

Sincerely yours,

J. W. FULBRIGHT.

[Enclosure]

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[6] "* * * Congress, as well as the two Presidents who recommended the legislation, clearly intended to eradicate an unhappy chapter in our history." *Hamm* v. *City of Rock Hill*, 379 U.S. 306, 315 (1964); *Heart of Atlanta Motel, Inc.* v. *United States*, 379 U.S. 241 (1964). See also House Report No. 914, 88th Cong., 1st Sess., p. 18; Id., Part 2, p. 2: "But this bill can and will commit our Nation to the elimination of many of the worst manifestations of racial prejudice."

[7] *Miller* v. *Robertson*, 266 U.S. 243, 248 (1924); Cf. *Phillips Petroleum Co.* v. *Wisconsin*, 347 U.S. 672 (1954); *Interstate Gas Co.* v. *Power Commission*, 331 U.S. 682, 691 (1947); *United States* v. *Scharton*, 285 U.S. 518 (1932). See memorandum, June 10, 1965, Laurence Davis to General Counsel, "Civil Rights Act; dismissal of Negro schoolteachers."

STUTTGART PUBLIC SCHOOLS,
Stuttgart, Ark., April 1, 1966.

Hon. J. W. FULBRIGHT,
U.S. Senate, Washington, D.C.

SIR: School administrators and board members are disturbed over the "Revised Statementof Policies for School Desegregation Plans Under Title VI of the Civil Rights Act of 1964" which has just been handed to us.

1. It changes our plan for desegregation which we accepted last year and which we have kept in good faith after approval from the Department of Health, Education, and Welfare.

2. The revised orders violate the Civil Rights Act of 1964 in requiring racial balance in schools and goes much further than Congress intended.

3. Changes demanded have come to us after obligations and contracts with teachers have been made and compliance with them will force the administration and school board to renege on contracts and commitments already made to teachers and pupils.

4. The policies force the use of certain language, which is not the will of the school authorities, in notices to parents and advertisement in the paper and requires that the school adopt it in toto. When official freedom of expression is denied, the time is not far away when personal freedom of expression also will be denied.

5. The time schedule for advertisement and registration of pupils cannot be met because of the late notice to the schools.

6. The severity of the changes will create antagonism among teachers, pupils, and patrons and, hence, will cause serious problems in administration of the schools.

7. It destroys all confidence on the part of those who have thus far worked to meet the law with courage and sincerity because we find that we cannot trust the authorities who approved our original plan.

8. It leaves the feeling that the Civil Rights leaders are using a club to force their will and show no respect for our rights or opinions. There can be no enthusiastic attempt on the part of administrators or board members to comply with such orders and the entire school system will suffer.

9. It places financial strain on schools to advertise, send letters, and employ additional clerical assistance to get letters to patrons.

10. It makes no provision for local traditions and opinions but assumes that all situations can be handled in the same manner. There are some 150 or more schools in Arkansas that have none or few negroes while some have as much as 60% negro.

11. It imposes a tyranny over our schools which affects the lives of all our people and destroys their faith in our government.

12. We feel that we should be allowed to continue with the three year plan which was approved by the Commissioner of Education and which the schools and its patrons have accepted. Continual and more stringent regulations will but lead to resentment and possible rebellion.

We enclose with this letter the following documents:

1. The Form 441–B we are now required to sign for participation in Federal Funds. The revised statement of policies for school desegregation plans of March, 1966. The mandatory texts of notices, letters, and choice forms prescribed by the Commissioner of Education for use with school desegregation plans of March, 1966.

2. Guide Lines for school desegregation dated March 1, 1966.

3. Photostatic copy of clipping from Gazette of April 1, 1966.

Last week a team of advisors was sent into the State by the Office of Education of the Department of Health, Education, and Welfare. This team met with the School Superintendents and School Board Members from throughout the State at Little Rock on March 23, 1966. The attitude of this team, to say the least, was arbitrary on racial balancing, without regard to academic standards and qualifications. The team consisted of the following persons from the office of Dr. David Seeley, U.S. Office of Education: Mr. John Hope, Mr. John Hodgson, Miss Caren Kareger.

Our purpose in writing you and telephoning you as we have is with the hope that we can stir the Arkansas Delegation in Congress to do whatever it can

to persuade the Department of Health, Education, and Welfare to modify its policies so as to permit us to work out our desegregation problems within the three years set by that Department without annual or more frequent departmental interference of the type displayed in these new regulations.

The Civil Rights people have been pouring the pressure on the Department. These regulations under the guise of "Guidelines" are a result of that pressure. It is high time organized pressure from the opposite direction be applied to this department. We may be uninformed, but we feel that no organized pressure has yet developed in Congress (and that is where it should come from since this is a usurpation of Congressional authority even more so than of ours) to counteract the pressures brought by the radical Civil Rights people.

We are asking that the Arkansas Delegation in Congress, if necessary, assume leadership and initiative in developing a movement on the Congressional level directed at the Office of Commissioner of Education to keep its regulations within bounds.

May we enlist your leadership and assistance in this effort? We make this request notwithstanding we may vote to file a compliance report under the new "Guidelines". Our acceptance will in no manner right the wrongs created by these regulations.

We realize that the Department may seek to deny this district Federal Funds and may seek to impose other sanctions against us for this expression of opinion. We feel so strongly about the issue that we are willing to take than risk.

Very truly yours,

LELAND STRATTON,
Board of Education, Stuttgart Special School District No. 22, Arkansas County, Ark.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
OFFICE OF EDUCATION,
Washington, D.C., May 24, 1966.

Hon. J. W. FULBRIGHT,
U.S. Senate,
Washington, D.C.

DEAR SENATOR FULBRIGHT: This is in response to your letters of April 5 and 26 regarding the 1966 school desegregation guidelines and Title VI of the Civil Rights Act of 1964. In your first letteer you sent on to us a letter to you from Mr. Leland Stratton, President of the Board of Education in Stuttgart, Arkansas, and requested that I (1) discuss the differences between the 1965 and 1966 school desegregation guidelines; (2) explain the reasons and authority for the changes; and (3) comment specifically upon the numbered assertions in Mr. Stratton's letter. In the second letter you stated that Arkansas has made a conscientious start in the desegregation of its schools, pointed out that elected school officials have to be able to lead their constituents if desegregation is to be orderly, and expressed the hope that I could assure you that in the administration of the guidelines, due regard will be paid to the differences among the various school districts of Arkansas.

I believe that Secretary Gardner's letter of April 9 provided at least a partial answer to your questions, but because of the breadth and importance of the issues raised in your letter, a more detailed answer to your questions seems desirable. Because your second request raises legal questions, I asked my staff to prepare a special memorandum on the authority for the guidelines, and in particular on the provisions respecting faculty desegregation and the effectiveness of free choice plans, both of which are matters of much concern to school officials affected. A copy of this memorandum and other materials which I believe will give useful background information are enclosed.

Much of the concern about the 1966 guidelines in general, and about the two key provisions mentioned above in particular, arises from a belief held by many that it is constitutional to maintain a system of separate schools for Negro and white children, with separate Negro and white faculties, as long as any Negro child who so wishes may attend a white school. As you know, of course, this belief is erroneous. The decisions of the Supreme Court and the lower Federal courts discussed in the enclosed memorandum make it clear that the maintenance of a dual system of schools for children of different races is unconstitutional, and that it is the duty of local school officials to establish a single system of schools for all children, white and Negro. The decisions also make it clear that desegregation necessarily includes faculty desegregation and that delay in desegregating schools is no longer tolerable.

As your second letter points out, Arkansas has made a start in the desegregation of its schools. Last fall, some school systems in Arkansas completely desegregated their schools and most others started desegregation in accordance with the 1965 guidelines. Most of these school systems agreed to assign students to particular schools on the basis of the choices made by pupils' parents. Most districts agreed to start faculty desegregation by holding joint faculty meetings and in-service training programs on a desegregated basis. Working under the 1965 guidelines, many school systems made significant progress. In these systems, a significant proportion of Negro children entered desegregated schools and school officials made preparations for teacher desegregation. But other school systems made less progress, and some made no progress at all.

In some instances, progress was thwarted by the attitude of school personnel, both Negro and white, who made it clear that Negro children should choose to stay in "their" Negro schools. In other instances Negroes believed that if they chose white schools for their children, they would incur the displeasure of the white community, and perhaps suffer economic injury. Such beliefs may, in many cases, be incorrect, but they are nevertheless very real to the Negro parents who hold them. Even in communities where desegregation is well accepted, Negroes who have been taught all their lives that Negro children belong in "their" Negro schools are reluctant to send their children "over there to the other school." It has been our experience that problems such as these can be overcome only by extensive preparatory work in the Negro and white communities. When such work has not been done, there has been little progress.

But whatever the problems encountered by the school systems which have made little or no progress, the law is clear—school systems with a dual school structure must proceed expeditiously in converting to a single, unsegregated school system. This is a local responsibility. Hence, the 1966 guidelines reflect the expectation, supported by the law, that school systems in carrying out their responsibility to desegregate their schools will be able to progress significantly further in the 1966–67 school year than they did in 1965–66. The differences between the 1965 and the 1966 guidelines are not differences in principle. They differ only in placing more emphasis on performance, requiring that progress be made in 1966–67 beyond what was achieved in 1965–66, when schools were starting desegregation.

Of the specific differences between the 1965 and 1966 guidelines, perhaps the most important concern teacher desegregation. But first of all, it is important to note that the 1965 guidelines also required that "all desegregation plans shall provide for the desegregation of faculty and staff" and that steps shall be taken to eliminate past segregated assignments. The impression that the faculty desegregation requirements are new arises from the fact that school districts beginning desegregation were permitted, during the first year, to prepare their staff for desegregation by joint faculty meetings and in-service training programs (Section V–E–4 of the 1965 guidelines). The 1966 guidelines define the objective of faculty desegregation in greater detail than did the 1965 guidelines. The pattern of teacher assignments to schools "may not be such that schools are identifiable as intended for students of a particular race." Moreover, the 1966 guidelines indicate that there must be actual progress in teacher desegregation. "Staff desegregation for the 1966–67 school year must include significant progress beyond what was accomplished for the 1965–66 school year in the desegregation of teachers assigned to schools on a regular full-time basis." The guidelines give several examples of what school systems might do in 1966–67 for staff desegregation. One example is "some desegregation of professional staff in each school." There is, however, no requirement that there be any particular pattern or proportion of staff desegregation. Each district is free to proceed as best suits its situation, as long as the progress is real. The enclosed memorandum shows that the staff desegregation provisions are in accord with the decisions of the Federal courts.

Another important difference between the 1965 and 1966 guidelines appears in the section concerning the acceptability of free choice plans. Last year the guidelines provided (Section V–D) that:

"The responsibility to eliminate segregation rests with school authorities and is not satisfied by rules and practices which shift the burden of removing discrimination to the class or classes of persons previously discriminated against. Desegregation of a school system may, however, be initiated by a "free choice"

plan [that assigns pupils in accordance with the standards of the 1965 guidelines.]"

The 1966 guidelines continue to accept free choice as a means of undertaking desegregation (Section 181.11). But the 1966 guidelines place greater emphasis on the responsibility of school officials to obtain community support so that their free choice plans will be an effective means of desegregation (Section 181.54). They provide that if the choices made will lead to only a small degree of desegregation in 1966–67, usually the second year of desegregation, the U.S. Commissioner of Education may review the plan to determine whether it is an effective means of meeting the school system's obligation to desegregate. On the basis of all the information gathered in such a review, the Commissioner may take up with the school system further steps that it should take in order that there will be reasonable progress in 1966–67 toward establishing a single desegregated system of schools. In order to give school officials a guide to the standards the Commissioner would use in scheduling plans for review, the section states, in percentage terms, the performance that would normally be expected in several situations. Here again, this section reflects the expectation that where local officials implement their plans responsibly, reasonable progress will be made in desegregating schools, but does not set down any rigid requirements of what that progress must be. Each school system's situation will be reviewed according to the facts applicable to it. These guideline provisions, as the enclosed memorandum shows, are in accordance with the court decisions that school systems must move forward in desegregation.

The 1966 guidelines contain several provisions which were not in the 1965 guidelines. For example, Section 181.42 provides that a high school student's own choice of school will be binding if his parents do not choose a different school within the choice period. This provision should make free choice plans a more effective means of carrying out the responsibility to establish a single system of schools. There are cases where parents are reluctant to choose a desegregated school for their children but may not object if the child makes his own choice of a desegrated school. In February and March, a Federal district court in Alabama included a similar provision in several court ordered plans.

Section 181.14 provides that a student attending school on a desegregated basis for the first time may not be disqualified from athletics and other activities because he is a transfer student. He may, of course, be disqualified for some other reason, such as failing grades at his previous school. In many school systems, students who transfer voluntarily are subject to a one year waiting period before they can play football, but students who are transferred by school authorities in, for example, a school consolidation, are under no such a limitation. Because changes in assignment under a free choice plan are made primarily to satisfy the obligation of the school system to desegregate its schools, rather than because of the transfer desires of the student, such transfers should be treated in the same manner as any other officially arranged transfer. In any case, a waiting period would discourage students under a free choice plan from changing schools and would make free choice plans less effective. This provision is supported by the Oklahoma City school desegregation decision handed down last September, which provided that each student transferring under that desegregation plan "shall have all the rights of the school [to which he transfers] academic programs, and athletic programs notwithstanding any rules to the contrary, inasmuch as the law of desegregation supesedes any rules requiring residence and time."

Section 181.15 provides that if the facilities at a school established and still maintained for students of a particular race are inferior to those generally available in the school system, the school should be closed and the students assigned to other schools. We have found that in 1966 there are places in the United States where Negro students are still segregated in one and two room schools, with little heat and no running water, while white children living in the same locality attend modern brick schools equipped with the latest teaching aids. Such Negro schools do not even meet the "separate but equal" standards developed in the years following *Plessy* v. *Ferguson*, 163 U.S. 537 (1896). The reason and authority for this provision are obvious. In the Lowndes, Bullock, Macon and Montgomery County, Alabama school desegregation cases decided in February and March, 1966 the U.S. District Court ordered the closing of 65 such small, inadequate schools.

A final difference between the 1965 and 1966 guidelines is found in the various forms issued with the 1966 guidelines. The 1965 guidelines described in general terms the contents of the notices school systems with free choice plans would use

to inform parents of their opportunity to exercise a choice of school. Each school was expected to write its own notices and include them with the plan sent to the Commissioner. Because a great many of these notices were inadequate for their purpose, much time had to be spent last summer in helping to prepare proper notices for many individual plans. The acceptance and implementation of plans for the 1965–66 school year was delayed, and so was the assignment of students to schools. As the result of this experience, it seemed desirable to issue with the 1966 guidelines appropriate texts for school officials to use in their notices, even though not everyone would agree with any particular wording.

There are, of course, other differences between the 1965 and 1966 guidelines, but because they do not seem to be controversial, there is no need to labor them here.

With regard to Mr. Stratton's twelve assertions, I will quote them in groups and follow with my comment.

1. It changes our plan of desegregation which we accepted last year and which we have kept in good faith after approval from the Department of Health, Education, and Welfare.

7. It destroys all confidence on the part of those who have thus far worked to meet the law with courage and sincerity because we find that we cannot trust the authorities who approved our original plan.

12. We feel that we should be allowed to continue with the three year plan which was approved by the Commissioner of Education and which the schools and its patrons have accepted. Continual and more stringent regulations will but lead to resentment and possible rebellion.

Comment.—The 1965 guidelines and the letter accepting this school district's plan stated plainly that changes in the guidelines and the district's plan might be necessary from time to time. But no changes of substance in this district's plan are required by the 1966 guidelines, if the plan is an effective means of desegregation in the district. The plan in this particular case provided for the desegregation of 8 grades in 1966–67 and 12 grades in 1967–68. There is no requirement in the new guidelines that this time schedule be changed. In accordance with the 1965 guidelines the plan provides for joint faculty meetings and in-service training programs as "a first step toward integration of faculty." The 1966 guidelines require that a second step be taken in 1966–67. Apart from the expectation that this school system make further progress under its plan in 1966–67 toward the desegregation of its students and teachers, the only changes to its plan required by the 1966 guidelines relate to matters of procedure and form, such as the uniform texts of the letters and notices, the reason for which was explained above.

With regard to the possibility of "rebellion," I have commented below in connection with item 6.

2. The revised orders violate the Civil Rights Act of 1964 in requiring racial balance in schools and goes much further than Congress intended.

Comment.—The concern here arises from the percentages in § 181.54. These percentages have been misinterpreted by some as requiring "racial balance," or a particular percentage of Negro children in schools with white children. As I stated in the discussion of § 181.54 above, the percentages are in the guidelines to give school officials some guidance as to a reasonable degree of progress that might normally be expected under free choice plans. Depending on the circumstances, failure to make the indicated progress might, or might not, mean that school officials should take further steps or change their plan so that there will be progress. The guidelines do require that reasonable progress be made, but nowhere do they require that there be any particular proportion of Negroes and whites in any particular school. The "correction of racial imbalance" is a phrase referring to the bussing of children from neighborhood schools which have not been officially segregated, but which, because of residential patterns, are "racially imbalanced." The guidelines do not deal with this situation at all.

3. The changes demanded have come to us after obligations and contracts with teachers have been made and compliance with them will force the administration and school board to renege on contracts and commitments already made to teachers and pupils.

Comment.—I regret that it was not possible to issue the guidelines until March 7. It appeared desirable, however, to consult a great many persons within and without the Government, including many State and local school officials, during the preparation of the guidelines. Arranging the consultations and making use of the advice given us took longer than was anticipated. Nevertheless, the fact that the guidelines were under revision was widely reported in

the press, and chief State school officers were kept informed. The provisions of last year's guidelines and our statements while the guidelines were under revision were such that responsible school officials should have been preparing for further progress in teacher desegregation next fall.

4. The policies force the use of certain language, which is not the will of the school authorities, in notices to parents and advertisement in the paper and requires that the school adopt it in toto. When official freedom of expression is denied, the time is not far away when personal freedom of expression also will be denied.

Comment.—As I explained above, our experience last summer demonstrated the advantages both to local school officials and to the Office of Education of providing acceptable notices and forms ahead of time and on a uniform basis.

5. The time schedule for advertisement and registration of pupils cannot be met because of the late notice to the schools.

Comment.—The choice period required by the guidelines could start as late as April 1, 25 days after the guidelines were issued. Section 181.62 states that if a required procedure is not feasible, the Commissioner may accept an alternative if he determines it will accomplish the same purpose. Late starts have been permitted when there is a good reason for them.

6. The severity of the changes will create antagonism among teachers, pupils, and patrons and, hence, will cause serious problems in administration of the schools.

8. It leaves the feeling that the Civil Rights leaders are using a club to force their will and show no respect for our rights or opinions. There can be no enthusiastic attempt on the part of administrators or board members to comply with such orders and the entire school system will suffer.

10. It makes no provision for local traditions and opinions but assumes that all situations can be handled in the same manner. There are some 150 or more schools in Arkansas that have none or few Negroes while some have as much as 60% Negro.

11. It imposes a tyranny over our schools which affects the lives of all our people and destroys their faith in our government.

Comment.—I am, of course, well aware that there are those who doubt the wisdom of the school desegregation decisions, and the Civil Rights Act of 1964. I am also aware, that in some places, providing leadership so that pupils, parents, teachers and the community will accept desegregation is a most difficult task. But, as the enclosed memorandum points out, it is the law that desegregation must proceed expeditiously. Furthermore, it has been our experience that attitudes often change faster than would appear possible beforehand, and that with determined and resourceful leadership, school systems can make significant changes in a short period of time, to the benefit of all concerned. The guidelines provide for flexibility and by no means require precipitous change where local conditions require otherwise. Where local officials assume responsibility locally to bring about the change in a planned and orderly fashion there has seldom been trouble. The complaints of Federal interference and predictions of disorder usually come from communities that have not assumed local responsibility for desegregation.

Needless to say, to the extent of our resources, we will work with school officials to help make desegregation a success. I believe most school officials are aware that under Title IV of the Civil Rights Act of 1964, the Office of Education has consultants available who can provide school officials with on the spot advice about desegregation. It can also arrange for institutes and in-service training programs which will help school personnel deal effectively with the problems of desegregation. We have found that these programs can be very useful in overcoming the problems to which Mr. Stratton refers.

9. It places financial strain on schools to advertise, send letters, and employ additional clerical assistance to get letters to patrons.

Comment.—We are aware that the cost of printing, and sending out notices has to be met from lean budgets. But if a desegregation plan is to be effective it is essential that parents to given direct and individual notice of the plan and how it affects them. Furthermore, it should be noted that far more than the cost of the one mailing is still being spent, even today, on bussing and other arrangements made to preserve segregation.

In closing, I can assure you that there will be no doubt of the compliance with Title VI of Arkansas school systems which are proceeding with reasonable speed to establish a single system of schools. We will have to work closely with those districts which are making less progress and we will, of course, take into ac-

count their particular problems. If there is any assistance we can give to you and your staff in working with such school districts I hope you will call upon us.

Sincerely,

HAROLD HOWE II,
U.S. Commissioner of Education.

Secretary GARDNER. Would you like me to come back tomorrow with full information on this so that we could have a dialogue about that?

Mr. NATCHER. If it meets with your approval, Mr. Chairman, after the other members have had their turn I would like to come back for a question or two.

Secretary GARDNER. I would be happy to do it and we could bring people who would provide additional information.

Mr. NATCHER. Thank you.

Thank you, Mr. Chairman.

Mr. FLOOD. Mr. Smith?

TOTAL PERSONNEL INCREASE

Mr. SMITH. What is the total number of personnel that you are proposing to increase?

Secretary GARDNER. About 4,000.

Mr. SMITH. How many of them represent a transfer from another department over to your department?

Mr. KELLY. Just a very small number, considerably less than a hundred.

Mr. SMITH. You have a total budget of $13.3 billion; is that right?

Secretary GARDNER. Yes, sir.

HEW PAYMENTS TO STATES AND LOCALITIES

Mr. SMITH. What part of that represents federal tax-sharing with local governments or Federal money that local governments would have to provide to give the same level of services if these services were not provided by the Federal Government?

Secretary GARDNER. Mr. Kelly says $8 billion.

Mr. KELLY. $7,448,000,000 goes to States and localities and covers public assistance, educational grants——

Mr. SMITH. What about payments to trust funds? Are these trust funds that will be used for local and State grants eventually?

Mr. KELLY. No. I think if the States have a maintenance program or Medicare program, it is very likely that people in need in States and localities would be greatly assisted. But the moneys expended from the trust fund go directly to individuals for monthly payments or through intermediaries for payment to hospitals——

Mr. SMITH. It does not replace the county hospital?

Mr. KELLY. No.

Mr. SMITH. So in effect that goes to relieve local taxes?

Secretary GARDNER. A very large part of it.

Mr. SMITH. What other grants are in the $1.4 billion?

Mr. KELLY. About $1.1 billion of these would be construction grants and about $400 million is in the nature of demonstration and special project grants.

Mr. SMITH. Have you separated construction grants to know what portion of those go to State and local institutions?

Mr. KELLY. I have them broken down for higher education. Some of the hospitals would be State and local and some of the educational grants would be——

Mr. SMITH. To get an answer to my question. In order to know how much goes to State and local government, one should add to the $7.4 billion the portion of the other grants that really go to State and local governments, together with the part of trust funds that goes to State and local.

Mr. KELLY. I will do that for you.

Mr. SMITH. I would like to know what part of the $13.3 really is tax-sharing for local governments for purposes they otherwise would be supporting.

Mr. KELLY. Let me take a stab at it.

TITLE I PAYMENTS

Mr. SMITH. What percent under title I will the school districts nationwide get in 1966–67 compared to the previous year?

Mr. KELLY. In 1966 these expenditures approximated $950 million. This fiscal year 1967 the expenditures will approximate $1,050 million.

Mr. SMITH. Is the 85 percent a partial payment?

Mr. KELLY. No.

In fiscal year 1966, although the appropriation was $959 million, we were authorized to make an allocation among the States that was $1.151 billion. So the 85 percent refers to this larger figure. It was 85 percent of the $1.151 billion. It was in the nature of a partial payment. But it was a recognition that the 1967 appropriation was not as large as was authorized to be distributed in 1966, but not fully used.

INCREASED HOSPITAL COSTS

Mr. SMITH. You said that hospital costs are going up, but what is the cause of it? What are the ingredients in the increase?

Mr. COHEN. Somewhere between 60 to 70 percent of hospital costs are salary costs. And a large proportion of this is for nurse and nurse-technician salaries, which have traditionally been low in relation to competitive areas in the community.

Quite frankly, it was better for a girl to become a secretary than become a nurse with all of that training because she could do as well. So nurse salaries have naturally been rising.

The other major factor is that because of all the equipment and technological development, the ratio of labor to patients has been rising over the last 25 years. Whereas about 25 years ago the number of employees in a hospital per patient-day was something like maybe one and a quarter, it is now I think in the nature of two and one-quarter.

As the Secretary said, unless more efficient methods can be brought into the hospital, costs will continue to rise.

The only thing on the other side that has been helpful in keeping total costs down is that the number of days per hospitalization has declined. As you all know in connection with maternity, whereas women used to be in many times 8 or 9 days, now it is in the nature of 3 or 4, and this is true for a whole series of illnesses.

EFFECT OF UPGRADED NURSING HOMES ON HOSPITAL COSTS

Mr. SMITH. Will the upgrading of some of the nursing homes so people can go from the hospital to a nursing home earlier offset any considerable percentage of this cost?

Mr. COHEN. It will offset some of the total dollar cost in hospitalization, but it will have the effect of greatly increasing the costs of nursing homes, which is another factor in Medicaid that causes the increase in cost because such a large proportion of people as they get older, let's say over 75——

Mr. FLOOD. You mean Medicare rather than Medicaid?

Mr. COHEN. I meant Medicaid, because Medicare only deals in a minor way with nursing homes. The extended care facility benefit in there is a very small part of total Medicare costs. But when you come to Medicaid and the average age of people on old-age assistance is 75 years of age, among the 2 million people receiving old-age assistance——

Mr. SMITH. But the ones not ill and not hospitalized will not be in the higher grade nursing home.

Mr. COHEN. No, they will not. But one of the reasons why we did not make recommendations this year for expansion of nursing home facilities is because we are somewhat concerned about the effect of a Parkinson's law here. If you built more nursing home beds, people would use more nursing home beds and costs would continue to rise without any real change in the delivery of medical care or the efficiency or economy of service.

Mr. SMITH. This will have the effect to help keep Medicare costs down, will it?

Mr. COHEN. It will. But I must say again, the thing I am concerned about very much in connection with Medicaid is the impact of nursing home costs for facilities and services.

INCREASED DOCTORS' FEES

Mr. SMITH. What about doctors' fees? What is the percentage of increase?

Mr. COHEN. Doctors' fees have risen of course in the last year, not nearly as much as hospital costs, but they have risen substantially more than the overall cost of living has.

Mr. SMITH. What is the percentage, do you know?

Mr. COHEN. I think it is in the nature of 7 to 8 percent.

Secretary GARDNER. 7.8 I think.

Mr. COHEN. As compared with let's say 4 percent in the general cost of living.

Here you have a number of factors at work. Of course the provision in the Medicare program for the payment of the customary and prevailing charges that doctors have made has probably meant some averaging upward. In a period when costs were generally rising anyway, there was probably some overall readjustment in costs. But basically, in my opinion, that was due in part to the fact that, with the shortage of doctors and greater demand for services, you get what you get in a normal competitive situation in any market—if there is a greater demand, greater utilization, and a shortage, the price is going to rise.

Mr. FLOOD. As the income of the average American has risen so tremendously, they make use of the service. They can pay for it.

RATIO OF DOCTORS PER CAPITA

Mr. SMITH. What about the ratio of doctors per capita?

Mr. COHEN. The ratio of doctors per capita has been remaining stable and not improving. Because of the Health Professions Educational Assistance Act, we hope we can do a little better. But the situation is in not improving rapidly enough to do three things: It is not improving rapidly enough to take care of the population getting older, who require a greater volume of health services than other people. Not enough is being done to take care of the unmet needs of the children. And not enough is being done in the great urban areas where we have so many low-income people.

IMPACT OF HEALTH PROFESSIONS ACT ON DOCTORS PER CAPITA

Mr. SMITH. How long will it be before the Health and Professions Act will make enough of an impact to improve the ratio of doctors per capita?

Mr. COHEN. I think that by 1969 or so the situation will be much better than it is at the present time. But still probably not good enough to take care of this demand for services, unless you get something like physician assistants or some other help for the doctors to increase their efficiency.

Mr. SMITH. There have not been very many additional classrooms for medical schools built yet, have there?

Mr. COHEN. There have been some. And under the Health Professions Act the number of individuals being trained has increased. But of course, as you will understand, if you take in a freshman class next year you know it is going to be probably in the nature of 8 or 9 years before that output has really affected patient care in a community.

EFFICIENCY OF HOSPITALS

Mr. SMITH. What about the efficiency angle that you mentioned?

You said that these hospitals are not operating as efficiently as they should.

Secretary GARDNER. Yes, sir. This is a long-standing problem with hospitals. They have some very special management problems, partly because——

Mr. SMITH. Doctors do not want administrators to administer the hospitals?

Secretary GARDNER. In a nutshell.

Mr. SMITH. You are not going to change that very soon, are you?

Secretary GARDNER. No, sir; but I think we are getting a caliber of administrator in the hospital who is himself sufficiently professional that he can deal with doctors on that level, and the doctors themselves are beginning to understand the impact of some of these cost items. We are also learning a lot about facilities and equipment and how you can get the kind of facilities that will keep costs down and will process patients through fairly rapidly into out-patient situations and home health care situations.

STUDY OF PUBLIC HEALTH SERVICE HOSPITALS

Mr. SMITH. In this same field you mentioned, I do not know the language you used, but you are going to make some kind of study where the hospitals are operated under the Health Service.

Secretary GARDNER. Yes. Mr. Kelly was talking about that.

Mr. SMITH. Is this being coordinated with the tremendous volume of data available from veterans' hospitals?

Mr. KELLY. Yes, sir; a committee was established of which Dr. Leaser is the chairman, an interagency group. In that group there are people serving from the Veterans' Administration and from each of the military services and the Public Health Service.

Mr. SMITH. So really this is going to be of all hospitals, including veterans' hospitals?

Mr. KELLY. That is correct.

But what happened with respect to the Public Health Service hospitals that makes them uniquely capable of doing something in this area is that there has been a dispute going on for a number of years as to what the future of those hospitals should be. During the entire time this dispute has been going on, the physical facilities have been deteriorating at a rapid rate. This issue was reviewed by the Congress I think in eight committees last year, and the decision was made that these hospitals were going to be continued.

The President concurred in that decision and he directed both the Budget Bureau and the Department of Health, Education, and Welfare, and specifically the Surgeon General, to take steps to modernize these hospitals and make them first-class facilities.

Mr. SMITH. How many are there?

Mr. KELLY. Ten general hospitals and two specialized hospitals exclusive of the Indian hospitals.

Mr. SMITH. Do you have a uniform system of recordkeeping in any of those hospitals?

Mr. KELLY. They do but they are badly in need of modernization.

Mr. SMITH. But they are uniform?

Mr. KELLY. Yes.

Mr. SMITH. Do you follow the system of the Veterans' Administration?

Mr. KELLY. No. Interestingly enough we use the Kaiser Permanente system of California.

TEACHERS CORPS COST

Mr. SMITH. The Teachers Corps cost apparently was in the neighborhood of $14,000 per Teachers Corps participant. Of course that is on a 1-year basis. Have you any cost projections as to what it would be if it ran 2 years or 3 years or 4 years? Will it reduce or remain stable?

Secretary GARDNER. It will reduce per capita. The cost of recruiting, the cost of advertising and processing, screening, and so forth are pretty much the same. The first year was an expensive year, so I would guess it would go down.

Mr. SMITH. Do you have any cost projections?

Mr. KELLY, We will have when we appear on that.

Mr. CARDWELL. As we mentioned earlier these costs are a composite of a number of units costs—training, transportation, salaries, et cetera.

Mr. KELLY. We will give you that.

(The information requested appears on page 95.)

Mr. SMITH. That is all at this time, Mr. Chairman.

Mr. FLOOD. Mr. Casey.

MEDICAID

Mr. CASEY. Mr. Secretary, earlier in your discussion with the chairman you mentioned there was probably going to be a limitation on the amount of medicaid. Did you not say it would be approximately 150 percent of the State's welfare payments? How do you propose to establish that? Will it take legislation?

Secretary GARDNER. It will take legislation and the whole matter is before the Ways and Means Committee at the moment.

Mr. COHEN. That would be done rather simply. What is in the legislation is that if a State had an income eligibility requirement for an aged person of $1,200, 50 percent more, which would be $1,800, would be the income limit of Federal participation in the cost of medicaid benefits for a single person. It keeps those two related.

Mr. CASEY. That would be their eligibility, that their income would not exceed $1,800?

Mr. COHEN. In that hypothetical illustration.

Mr. CASEY. They would then be eligible for medicaid?

Mr. COHEN. Up to that. If they had a higher income they would have to pay it out of State funds.

Secretary GARDNER. Or lower it.

Mr. CASEY. I wondered how that would work.

Mr. COHEN. The rationale behind medicaid is that there is a little higher level for medical indigency than for cash participation. This is 50 percent higher than the cash participation level.

Mr. CASEY. Do you prefer that type of limitation rather than a nationwide limitation?

Mr. COHEN. Well, in the executive sessions of the Ways and Means Committee last year we were about 8 weeks exploring whether there could be a dollar limitation. The Committee came out with no recommendation on that point because they could not find one that was satisfactory to all of the States. They instructed us to study this problem further, and it was out of that that this standard came out which was more flexible but at the same time put some kind of lid on it. We are continuing to look into the matter as to whether any other method could be developed. The committee last year looked into the question of using the per capita income of the State as a basis but they did not come up with a recommendation on that.

Mr. CASEY. You have about 28 States participating in medicaid?

Mr. COHEN. Yes.

Mr. CASEY. Do you think all will be participating next year?

Mr. KELLY. We estimate 48 will be participating by 1968.

Mr. CASEY. That will not be the full year?

Mr. KELLY. Pretty much, by July 1 they will have adopted a plan.

SOCIAL SECURITY TAX INCREASE

Mr. CASEY. What do you anticipate the social security tax increase will be? What will be necessary to raise the minimum?

Mr. COHEN. The percentage would have to go up on the old age and survivor insurance payments from 4.85 to eventually 5 percent for both the employer and the employee. And it will also be necessary to raise the maximum earning base, at the present time $6,600 in three steps to $7,800, $9,000, and $10,800 to fully finance the recommendations the President has made.

FOREIGN RESEARCH

Mr. CASEY. On page 24 of your statement you state that this budget will support about 14,500 separate research projects conducted mainly by American scientists. How many foreign research projects do you have underway?

Mr. KELLY. We can get you a figure on it but there are not very many. Because of the outflow of gold problem a few years ago we took steps to constrain the amount. We do have substantial funds from Public Law 480 funds and are supporting in the order of $12,400,000 of research all over the world out of hard dollars which adversely affect the outflow of gold.

Mr. CASEY. Would you mind, at this point in the record, putting that in and showing which ones are U.S. dollars and which ones are Public Law 480 funds and the geographical distribution?

Mr. KELLY. I know I have it by major sections of the world.

(The information follows:)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Foreign research projects, fiscal years 1967–68

[Dollars amounts in thousands]

	Fiscal year 1967				Fiscal year 1968			
	U.S. dollars		Foreign currency		U.S. dollars		Foreign currency	
	Number of projects	Amount	Number of projects	Amount	Number of projects	Amount	Number of projects	Amount
Canada	63	$1,453	------	----------	56	$1,299	------	----------
Latin America:								
Argentina	17	203	------	----------	15	178	------	----------
Brazil	28	267	------	----------	25	235	2	$280
Chile	16	141	------	----------	14	124	------	----------
Colombia	5	142	------	----------	4	125	------	----------
Costa Rica	2	21	------	----------	3	26	------	----------
El Salvador	1	20	------	----------	1	20	------	----------
Jamaica	3	106	------	----------	4	131	------	----------
Mexico	12	149	------	----------	10	131	------	----------
Peru	14	270	------	----------	12	236	------	----------
Uruguay	6	138	------	----------	5	121	------	----------
Venezuela	7	133	------	----------	6	117	------	----------
Subtotal	111	1,590	------	----------	99	1,444	2	280

Foreign research projects, fiscal years 1967–68—Continued

[Dollars amounts in thousands]

	Fiscal year 1967				Fiscal year 1968			
	U.S. dollars		Foreign currency		U.S. dollars		Foreign currency	
	Number of projects	Amount	Number of projects	Amount	Number of projects	Amount	Number of projects	Amount
Europe:								
Austria	9	$55	----	----	8	$49	----	----
Belgium	13	148	----	----	11	131	----	----
Denmark	14	251	----	----	13	247	----	----
Finland	12	116	----	----	10	102	----	----
France	26	554	----	----	24	517	----	----
Germany	12	102	----	----	10	90	----	----
Greece	12	157	----	----	10	137	----	----
Ireland	3	15	----	----	3	15	----	----
Italy	40	539	----	----	36	553	----	----
Netherlands	18	349	----	----	19	406	----	----
Norway	10	138	----	----	9	121	----	----
Poland	3	5	17	$2,188	3	5	32	$3,940
Portugal	2	35	----	----	2	35	----	----
Spain	10	64	----	----	9	56	----	----
Sweden	44	1,005	----	----	39	881	----	----
Switzerland	10	110	----	----	9	97	----	----
United Kingdom	59	949	----	----	53	857	----	----
Yugoslavia	8	23	13	1,174	7	20	30	3,044
Subtotal	305	4,612	30	3,362	275	4,319	62	6,984
Africa:								
Guinea	----	----	----	----	----	----	1	20
Kenya	1	27	----	----	1	27	----	----
Liberia	2	91	----	----	2	91	----	----
Nigeria	5	165	----	----	6	190	----	----
South Africa, Republic of	15	311	----	----	12	251	----	----
Tunisia	----	----	1	26	----	----	8	585
United Arab Republic (Egypt)	----	----	13	1,802	----	----	17	2,175
Uganda	2	109	----	----	3	136	----	----
Subtotal	25	703	14	1,828	24	695	26	2,780
West Asia:								
Iran	7	56	----	----	8	64	----	----
Israel	52	1,029	52	4,450	45	904	68	8,237
Lebanon	10	238	----	----	10	241	----	----
Subtotal	69	1,323	52	4,450	63	1,209	68	8,237
South and east Asia:								
Australia	39	502	----	----	34	436	----	----
Burma	----	----	----	----	----	----	4	95
Ceylon	----	----	2	110	----	----	6	640
India	7	77	41	3,232	6	68	71	5,304
Japan	112	1,095	----	----	99	993	----	----
Korea	3	22	----	----	3	22	----	----
Malaysia	1	6	----	----	1	6	----	----
New Zealand	8	76	----	----	7	67	----	----
Pakistan	1	2	15	2,170	1	2	24	2,665
Papua and New Guinea	1	17	----	----	1	17	----	----
Philippines	4	161	----	----	5	199	----	----
Singapore	1	7	----	----	1	7	----	----
Taiwan	12	78	----	----	12	80	----	----
Thailand	1	18	----	----	1	18	----	----
Subtotal	190	2,061	58	5,512	171	1,915	105	8,704
International organizations	15	658	----	----	14	618	----	----
Grand total	778	12,400	154	15,152	702	11,499	263	26,985

Mr. CASEY. A couple years ago, Mr. Chairman, I heard a complaint that we were financing research projects and keeping some pretty good medical men out of the active practice.

Mr. FLOOD. Yes. We touched on that last year.

HOSPITAL CONSTRUCTION

Mr. CASEY. On the construction of hospitals, what is your level of funding for Hill-Burton funds for hospital construction? Is it about the same or have you increased it?

Mr. KELLY. It is the full authorization and the full authorization is increasing with respect to long-term care facilities and modernization a little each year, and decreasing a little each year for general hospital beds.

Mr. CASEY. Is that in keeping with the demands?

Mr. KELLY. Yes. At one time there was a recommendation before the Congress to hold down the number of general hospital beds and to put the emphasis into the modernization of urban hospital plants. This was a controversial subject. Finally, there was developed a formula which, over a period of several years, was designed to increase the amount of resources that would go into modernization and have an offsetting decrease of resources that would go in general hospital beds. The grant total in the budget for 1968 is $280 million. It was $270 million in 1967. Both of those amounts are the full authorization under that act.

Mr. CASEY. You see no need to anticipate an additional increase due to the implementation of medicare and more medicaid programs? You do not anticipate any increase in demand for hospital construction?

Mr. KELLY. We do not contemplate legislation to do that. The entire Hill-Burton Act will come up for reconsideration in the next session of Congress and there will have to be a reevaluation at that time. As Mr. Cohen indicated, a high degree of concentration is on the question of how you improve hospitalization utilization with a view to making the existing hospitals go further and also having the general hospitals serve only the acutely ill and taking those who require only custodial care out of the general hospitals.

Mr. COHEN. In the President's health message he recommended that there be a top level commission which he would appoint to study the whole matter of medical facilities, taking into account that Hill-Burton does expire in 1969. That would encompass new hospitals, modernization, nursing homes, mental health facilities and mental retardation facilities.

HIGHER EDUCATION FOR INTERNATIONAL UNDERSTANDING

Mr. CASEY. You have a request for "Higher Education for International Understanding." This is all domestic training?

Secretary GARDNER. And research.

Mr. CASEY. You have foreign language training and area studies under Fulbright-Hays. Will that be local or abroad?

Secretary GARDNER. Will you repeat that?

Mr. CASEY. I am looking at "International Education" in which you list programs by activities. You have (1) undergraduate programs and international studies; (2) centers for advanced international studies; (3) language and area programs; and under (4) you have foreign language training and area studies.

Secretary GARDNER. Yes, sir. That last item is under the Fulbright-Hays Act and it is domestic.

Mr. CASEY. It will all be domestic?

Secretary GARDNER. Yes, although I believe some of the money is used to permit language students to go to the country where the language is spoken so they will get a good speaking knowledge of it.

Mr. KELLY. I think one distinction should be made. The first two items are associated with the new program. In order that we could properly coordinate it, the Secretary has transferred the on-going programs in the Office of Education to the same center that will operate the new program. The Fulbright-Hays is an on-going program.

Mr. CASEY. And (3) language and area programs?

Mr. KELLY. That is not new either.

Secretary GARDNER. We will bring them into the same package.

Mr. CASEY. I think you should point that out.

Mr. CARDWELL. Only about $20 million of the 1968 request is for the new program.

CENTER FOR EDUCATIONAL COOPERATION

Mr. CASEY. What is proposed for the center for educational cooperation?

Secretary GARDNER. This is the administrative unit that puts all these programs together. It will be in the Office of the Secretary. It will be under Assistant Secretary Paul Miller, who came down from being president of the University of West Virginia to be my Assistant Secretary for Education. He is in charge of putting all these international programs together and the center is simply the administrative unit.

Mr. CASEY. And you anticipate a jump there from $475,000 to $1,775,000?

Secretary GARDNER. Yes, sir.

Mr. CASEY. What will that be, mostly salaries?

Mr. CARDWELL. In 1967 there will be a combined staff of 74 employees, 49 of whom are already engaged in Fulbright-Hays and title VI of the aid program.

Secretary GARDNER. It has done a fairly good job of getting the colleges and universities into this area so that they understand it. They are working with them, they are discussing it with them. It has been a blessing at this time with all the discussion of CIA and the like which raised questions as to our relations with the universities. The universities are in close touch with Paul Miller and have worked with him.

Mr. CARDWELL. Dr. Miller will appear when the supplemental is heard. There is a supplemental pending for $350,000.

Mr. CASEY. I will hold some of this for him, then.

IMPLEMENTATION OF CIVIL RIGHTS ACTS

Mr. Secretary, on the implementation of the Civil Rights Acts, as I understand it your guidelines must be approved by the President. Is that correct?

Secretary GARDNER. Regulations under which we operate must be approved by the President.

Mr. CASEY. What is the difference between regulations and guidelines?

Secretary GARDNER. We issued regulations after they were approved by the President and they laid down all the basic principles under which we operate. A number of the southern schools wanted further guidance and it is interesting that Frank Keppel's first reaction was that he would prefer not to send down more detailed advice to the schools. But Frank Keppel finally concluded that they should issue a set of statements that would serve as advice as to how to interpret the regulations, and that was the origin of the guidelines. These were simply a form of advice as to how to interpret the regulations. They did not introduce any new principles but they indicated pretty well how we were going to try to work our way through this complicated business. That is the source of all the controversial guidelines.

Mr. CASEY. Would it be fair to say the President approved the letter that went out the other day that was referred to here?

Secretary GARDNER. No. sir. I would be glad to give you a full statement.

Mr. CASEY. I think you are coming back tomorrow.

Mr. FLOOD. Yes. Mr. Natcher has requested that the Secretary return tomorrow.

We will adjourn until 10 o'clock tomorrow morning.

TUESDAY, MARCH 21, 1967.

Mr. FLOOD. The committee will come to order for the second day of hearings with Secretary Gardner on the fiscal year 1968 budget.

Mr. Laird?

STUDY OF TRAINING PROGRAMS

Mr. LAIRD. Mr. Secretary, the first item that I would like to discuss with you is the vocational training study which this committee recommended last year in the conference report. I would like to read the language of amendment No. 32 of that report at this time:

Reported in technical disagreement. The managers on the part of the House will offer a motion to recede and concur in the Senate amendment with an amendment which will retain the Senate amendment language that provides that $100,000 of the appropriation for "Salaries and expenses" shall be available only for the National Conference on Education of the Deaf and adds language that provides that $150,000 of this appropriation shall be available only for transfer to the appropriation "Office of the Secretary, salaries and expenses" for a comprehensive study of the administration of training programs financed partially

or wholly with Federal funds. The conferees do not intend that this study include training programs that agencies operate for their own employees or training of professional personnel but rather training under such programs as vocational education, institutional, and on-the-job training under the Manpower Development and Training Act, apprenticeship and training program, Job Corps, specialized training programs under title II of the Economic Opportunity Act, work experience program, work-study program, Neighborhood Youth Corps, etc.

This study is to have as its principal purposes to determine if there is waste, duplication, and inefficiency in administering these programs as many individual programs and, if this determination is in the affirmative, to make recommendations for correction. The study is to be made by a committee of experts in the field, none of whom are to be Federal Government employees, to be appointed by the Secretary of Health, Education, and Welfare after consultation with the Secretary of Labor and the Director of the Office of Economic Opportunity. It is the opinion of the conferees that it would be preferable if the committee's staff was also selected from outside the Federal Government.

What progress is being made on this committee that was recommended in our conference report of October 20, 1966?

Secretary GARDNER. Mr. Laird, I regret to say that my Department was exceedingly slow in acting on that recommendation. When we did begin to act on it we ran into a lot of difficulties in selecting an appropriate committee that would be suitable to us, suitable to the Labor Department, and have all the clearances. Then we encountered problems in finding an appropriate chairman. We are just at the point where I think we are close to choosing a chairman. Once we do that the whole thing will get underway. I mention these difficulties but I do not consider them an excuse for our slowness in getting this done. I regret that we did not seize the opportunity which you gave us to do this promptly.

Mr. LAIRD. Mr. Secretary, this committee had real concern over the fact that we are moving in this country toward a dual or a triple track education system, particularly at the high school level. The real responsibility for developing an educational program that would meet the needs of the future looking toward the year 2000 should be centered in the Department of Health, Education, and Welfare rather than any other department of Government because you are best equipped and best set up to meet this problem.

We look around us and we see that there are so many new programs being established and programs that have been established since the Department of Health, Education, and Welfare was created in 1953. We are concerned with this proliferation of responsibility for education and training programs. We are concerned that we are not getting the best use of the Federal dollar and we are not meeting the needs of the future.

I do not mean to be lecturing you because you are an expert in this field and I am not, but it would seem this should be given higher priority by the Department of Health, Education, and Welfare than it has in the past, and if there is anything I can do as a member of the committee to help, I would like to know just what it is.

Secretary GARDNER. Well, Mr. Laird, I think you have done the best thing that you could to help us in providing for this study and I believe that we can now proceed with energy. I am much clearer now than I was 6 months ago about the necessity for clarifying and defining the roles of various agencies in this effort. We will pursue it with the greatest possible energy from this point on.

VOCATIONAL EDUCATION WORK-STUDY PROGRAM

Mr. LAIRD. Mr. Secretary, did you appeal the reduction of the work-study program in vocational education to the Bureau of the Budget?

Secretary GARDNER. This was 18 months ago? That is the point of decision you are talking about, is it not?

Mr. LAIRD. Well, there were appeals taken, I believe, even later than 18 months ago so far as the Bureau of the Budget was concerned. I was particularly interested in whether an appeal was taken in that last stage to the Bureau of the Budget?

Secretary GARDNER. Yes, it was.

Mr. LAIRD. It was taken?

Secretary GARDNER. Yes.

Mr. LAIRD. The budget justifications say the reason for the work-study program being eliminated is that it will be absorbed by the Neighborhood Youth Corps. Yet the budget document seeks a decrease in funding for the Neighborhood Youth Corps. I do not believe the justification carried in the President's budget is a valid justification in view of the fact there is a decrease in funding of the Neighborhood Youth Corps. I would think the $10 million, or $20 million, in the work-study program in vocational education is a better use of funding than a similar amount of dollars appropriated to the Neighborhood Youth Corps.

ADMINISTRATIVE COSTS FOR NEIGHBORHOOD YOUTH CORPS AND VOCATIONAL WORK-STUDY PROGRAMS

Are you aware of the difference in cost of the Neighborhood Youth Corps as compared to the work-study program in vocational education?

Secretary GARDNER. I do not know the precise comparison.

Mr. CARDWELL. As Mr. Laird points out, the total budget for the Neighborhood Youth Corps in 1968 would be reduced. However, the budget does show an increase in the in-school Neighborhood Youth program. The program plans of the Office of Economic Opportunity would call for priorities to be given to vocational students in school but, as has already been pointed out here this morning, this is a policy decision which was not made in our Department. Our Department did propose continuation of the work-study program at a sum lower than the total budgeted now for Neighborhood Youth activities.

Secretary GARDNER. I do not know that he answered your precise question. Did he?

Mr. LAIRD. No. For one thing the cost of the work-study program handled by the vocational schools is much lower than the cost of the Neighborhood Youth Corps. In addition to that in the work-study program there is a 25-percent local or State contribution whereas in the Neighborhood Youth Corps program it is 90 to 100 percent Federal financed. And I have always found in these programs with local participation, either by school districts or by the States, you have a better program. I watched this vocational work-study program over the years and it has been one of the finest programs we have had. Just because it does not have a new title and is not a part of the war on poverty as such, it seems to be given a low priority in this budget.

Just because an item is not associated with the war on poverty does not seem to me to be a good enough reason for turning it down. The vocational schools have been very much a part of the war on poverty a long time before we even thought of that title.

I guess there is no reason to pursue that any further because this is a decision that will have to be made by the Congress now, but I want to express my disappointment. I wrote to you and asked that this be held up until we at least had an opportunity to conduct the budget hearings this year and act on the 1968 budget for the Department of Health, Education, and Welfare. The decision was made and you have now withdrawn the program. I think that was a mistake.

Mr. KELLY. The response did indicate it was too late to reconsider the decision, but in the conduct of the study, which the committee directed and which the Secretary has referred to, the long-term arrangements for the handling of this problem would be considered.

Mr. LAIRD. Mr. Kelly, I do not know why it was too late. I do not understand that.

Mr. KELLY. All the decisions had been made at the time we wrote to you. They were actually in print. It was really beyond revision at the time when we wrote to you.

ESTIMATES FOR PUBLIC ASSISTANCE

Mr. LAIRD. Mr. Secretary, in connection both with the budget that we have before us and in the supplemental request in which we have grants for public assistance, how firm is the estimate for grants for public assistance?

Secretary GARDNER. I think we have given indication that there may be a later additions to that requested for 1968. I would like Mr. Kelly to speak to it.

Mr. LAIRD. It seems to me that the President's budget for 1968 is not a very realistic estimate of the amount of money that will be needed.

Mr. KELLY. I think that is a good conclusion. When we advised the committee about the necessity for raising the amount of the supplemental for fiscal year 1967, it struck me that the same trends and experiences that caused 1967 to go up would likely have an effect on 1968.

We questioned ourselves as to whether or not we should at this point in time modify the 1968 estimate. We concluded it would be preferable to bring up a modification of the 1968 estimate after the Congress had had an opportunity to act upon the several provisions involved in the new social security legislation which will also have an effect on the 1968 requirements.

Mr. LAIRD. But based on the current law would you not say your estimate is off by about one-half billion dollars?

Mr. KELLY. No. We increased the supplemental by $188 million and I think our prediction was that the same trends would cause us to increase the 1968 estimate by about $200 million.

Mr. LAIRD. If you project the trends into the third and fourth quarters now you believe you have underestimated only by $200 million based on current law?

Mr. KELLY. Yes, sir.

Mr. LAIRD. So that the budget document that was submitted to us is underestimated in grants to the States by $200 million?

Mr. KELLY. In this neighborhood, yes.

ESTIMATED COST OF SOCIAL SECURITY AMENDMENTS

Mr. LAIRD. Is there a further underestimation in the budget document based on the social security amendments if they do become law? In addition to the $200 million you now say the budget document is off, what is the additional increment if the social security amendments become law?

Mr. COHEN. The social security amendments and the increased costs do not generally become applicable in 1968. To the extent the social security benefit increases are involved it will take about 200,000 people off of old age assistance, so there would be a reduction in the State liabilities.

Mr. LAIRD. But you will not put that on the back of every wage earner in America, will you? Those are welfare costs and you will not expect the wage earner to pay those costs.

Mr. COHEN. There are two illustrations that arise on the effect of the Social Security amendments. First there is the impact of Mr. Byrnes' and Mr. Prouty's amendments to pay people who are noninsured who now get a $35 a month—$52.50 for a couple—out of general revenues. Under the recommendations those payments are increased to $50 a month and $75 a couple. Individuals now receiving between $35 and $50 a month on public assistance will move off the public assistance rolls. Therefore there will be a group of people who will shift over and the States will in effect benefit.

Secretary GARDNER. How large is that group, Wilbur?

Mr. COHEN. I think probably 80,000 or 90,000 would shift over.

The other impact results from the increase of the minimum benefit from $44 to $70 and the 15 percent general increase in benefits, but mostly from the change in the minimum benefit. This will either take people off public assistance or reduce their assistance payments. So there will be some reduction for that but I would expect the States would have to plow that money back to increase their title 19 programs and to provide for the cost of living increases that are occurring.

Mr. LAIRD. Mr. Secretary, when we get a budget estimate for the 1967 supplemental at $281 million in January and less than two months later the actual request is for $470 million, this looks like pretty haphazard estimating. Do you have any comments on that, Mr. Kelly?

Mr. KELLY. We are disappointed that the trends we predicted did not materialize.

Mr. LAIRD. This was in two months.

Mr. KELLY. Although there are two months' difference from the date of publication of the document, the figures were actually compiled last summer.

Mr. LAIRD. This did not go to the printer until late December, very late December, it wasn't in final print until the middle of January.

Mr. KELLY. It was the potential for modifying the figure.

Mr. LAIRD. You modified some other figures when it looked like the budget was more out of balance than you wanted to estimate. You did not change this figure but you changed some other figures.

Mr. KELLY. At the time final decisions were made on the 1968 budget, we did not have the information from the States. We did get

indications that upward trends were developing. We were specifically asked to compile figures from the States for the medicaid program. We got the revised projections to you very soon after we had the data.

ESTIMATE OF PUBLIC ASSISTANCE GRANTS FOR FISCAL YEAR 1968

Mr. LAIRD. I really want to direct this question to the Secretary but I think perhaps you, Mr. Kelly, should answer it. Now is the time to get this figure pinned down as far as 1968 is concerned. We are considering the 1968 budget now. In the estimate for 1968 you estimate $4.24 billion for public assistance costs. I think that is approximately the figure?

Mr. KELLY. Yes, sir.

Mr. LAIRD. Based upon this estimate and the trend reflected in the supplemental which came up here last week, the total amount for 1968 could be closer to $5 billion. How are you arriving at this estimate of $200,000,000?

Mr. KELLY. We are doing it on the basis of the number of people who are receiving assistance, the average amount received per month, and the cost trends for the balance of this year and 1968. We will agree that the base on which our 1968 estimate was prepared was our original estimate for 1967. Then we made estimates of how many more people would go on assistance in 1968, how much the average payment would go up, and how many States would adopt medicaid and what the amount of money required for matching would be.

We think the increase in 1968 over 1967 still is a sound basis for estimating the States' requirements. We think the base on which we add the increase in 1968 over 1967 is understated and that you will have to increase that by about $200 million. But since there are three or four other variables involved we thought we could give you a firmer estimate if we waited until our social security proposals had been considered.

Mr. LAIRD. I am glad to have this assurance, but next year when the budget is presented for 1969 I think these assurances are not going to prove out to be too correct. I believe you will be here with a supplemental of much more than $200 million. It seems to me that this is some sort of a budget game that is being played between the Bureau of the Budget and the Department of Health, Education, and Welfare in order to show these costs at a lower figure to the Congress as we start our consideration of this 1968 budget and keep the budget from being even further in the red.

WELFARE COSTS IN SOCIAL SECURITY PROGRAM

Mr. Kelly went into the fact that perhaps some of these welfare costs would be reduced based on the proposed amendments to the Social Security Act. Mr. Secretary, what is your opinion of loading the insurance program with welfare costs?

Secretary GARDNER. Well, ever since the program began, it has provided benefits that were not wholly paid for by the people receiving them. When it began people who were 65 at that time began to receive benefits after as little as 1½ years of covered employment.

There have been efforts to provide more substantial benefits to the lower income groups and I think that is perfectly legitimate within

limits. I think it is a matter of balancing how far you want to go rather than an obsolute question.

Mr. LAIRD. The social security tax seems to me to be the most regressive tax to pay for welfare costs. It seems to me that if you are going to continue to load this program with welfare costs it should be financed on the basis of the ability of the taxpayer to pay. The program which is now before the Congress could possibly relieve some general fund costs, but it seems to me you are putting a burden on the young taxpayer, a burden which is not really buying any insurance as far as he is concerned. I would like to know if there is any policy on the part of the Department. Do you still want to continue to use this social security program in order to show welfare costs at a lower level? Almost all the programs that have been recommended this year are welfare programs. The people who will be receiving benefits will not have paid a single dollar for these benefits.

Mr. KELLY. May I comment on that?

One of the items I had in mind when I said I thought the legislation under consideration by the Ways and Means Committee would have an effect on public assistance payments is that the administration has recommended there be a limitation placed on medicaid, that it be 150 percent of the income criterion for cash assistance. This would lower the amount necessary for financing medicaid.

Secondly, there is a recommendation that all the beneficiaries under social security receive an average increase of 15 percent. About 7 percent of the social security beneficiaries aged 65 and over receive supplementation through public assistance. The supplementation requirements would be diminished by the fact they get an increased social security payment.

Mr. LAIRD. I do not understand that, Mr. Kelly. It seems to me the general fund should pay these costs.

Mr. KELLY. No. I must not have made it clear. This increase in payments to beneficiaries is not limited to those on public assistance. Only about 7 percent of aged social security beneficiaries are on public assistance.

Mr. COHEN. Your point is well taken that the people who will receive this increase have not paid for it.

Mr. LAIRD. What bothers me is how far you can go on this social security regressive tax without reimbursing the trust fund.

Mr. COHEN. We did state in the testimony to the Ways and Means Committee, in response to questions Mr. Byrnes asked the Secretary and myself, that there is a limit to how far you can go in using the payroll tax as a method of financing benefits which deal with what I would call social adequacy rather than welfare.

Mr. LAIRD. We always like to refer to the social security system as an insurance program. That is the way the fathers of the program from Wisconsin referred to it when they devised this system. You know that Wisconsin background.

Mr. COHEN. Yes; but I do not think the concept of insurance means each individual gets back exactly what he has put in. It can be a group insurance concept in which some people get back more and some people get back less but the group as a whole get back benefits related to what they put in.

UNFUNDED LIABILITY OF SOCIAL SECURITY TRUST FUND

Mr. LAIRD. What is the unfunded liability right now?

Mr. COHEN. About $350 billion, something in that neighborhood.

Mr. LAIRD. You say $350 billion. I have heard it estimated up to $400 billion, but you believe it is $350 billion now?

Mr. COHEN. Yes. Of course it would be increased by the passage of this legislation by something of the nature of about $67 billion.

Mr. LAIRD. So if this bill passes the unfunded liability of the social security program would be at least $400 billion?

Mr. COHEN. Yes, about $417 billion.

I do think that the issue primarily arises with regard to raising the minimum benefit. There has always been a minimum benefit in social security—where people get back a lot more than their contribution. It started out at $10 and now it is $44 a month. Even under the present law as far as $44 is concerned that is much more than the contributions the people have paid in that wage category. I think what you are saying is that the proposed increase is stretching that point unduly and should be paid out of general revenues. If the total value of the amount above what an individual would normally get in the formula were to be paid out of general revenues, I think the $70 minimum would require about $1.2 billion from the general fund.

COST OF RAISING MINIMUM BENEFIT TO MAXIMUM LEVEL

Mr. LAIRD. What about putting the minimum benefit up to the maximum level now to take care of these people that are having the most difficulty in meeting their costs, putting everybody up to a maximum benefit?

Mr. COHEN. Then I think you would have something like flat assistance.

Mr. LAIRD. We asked Mr. Meyer to give me an estimate of what the cost would be to put everybody at a minimum overall income level equal to the present maximum benefit at this particular point and do away with your old-age assistance program, and I think it comes out to about $5 billion. I thought it would be much more than that.

Mr. COHEN. That must be correct. I thought it would be more than that, too.

Mr. LAIRD. The problem we have in this committee is we seem to be loading a great amount of costs on the social security program. What is the term you use?

Secretary GARDNER. "Social adequacy."

Mr. COHEN. That comes out of Wisconsin, too.

Mr. LAIRD. You use that instead of welfare?

Mr. COHEN. I think if you read the writings by the Wisconsin masters you will find they use "equity" and "social adequacy." "Social adequacy" refers to the social needs of people.

Mr. LAIRD. So rather than refer to them as insurance benefits or welfare benefits you use these other words?

Mr. COHEN. These two phrases were actually coined by the vice president of the Metropolitan Life Insurance Co.

COST EFFECTIVENESS STUDIES IN HEALTH PROGRAMS

Mr. LAIRD. The President's budget message indicates that the Department of Health, Education, and Welfare is using "cost per life saved and other criteria of relative effectiveness" to reexamine the funding priorities for health programs. This is a quote from the budget on page 37. When I ran into that I thought I was dealing with something in the Department of Defense, not with human problems but weapons systems or something like that.

First, Mr. Secretary, bearing in mind this quote from the President's budget, are you establishing the priorities the message refers to by running health programs against one another based on their ability to pay for themselves?

Secretary GARDNER. We are examining all our programs to see what we get for our dollar and what we might get through alternative strategies and alternative ways of spending our money. It seems to be particularly applicable in health because there are particular results you can count. There are countable events. It is much more difficult in education where many of the results are not clear. You can take many investments in health and say that in one of them a dollar will buy a large number of lives saved and illnesses reduced, and in another a dollar spent will have much less effect.

I do not know if you have seen these studies which we have published. An example is in driver safety. You can take all the safety measures you might use in connection with automobiles and ask where a dollar spent will save the most lives. You can actually calculate the ratios. We have those figures and those charts and it comes out a dollar spent on seat belts and instructions as to the use of seat belts has such a high ratio of effectiveness in terms of lives saved that you immediately feel that putting money into this program has a tremendous impact on the public good.

Mr. LAIRD. Does this approach in the field of health programs assume, or will it in the long run, a move toward substituting ultimate economic results such as the contribution to the gross national product less disability payments, et cetera, for humanitarian purposes?

Secretary GARDNER. No, sir. The sought-for consequences may be economic in the sense you are counting the number of disabled people you have put back in employment, but it may also be the humanitarian concept that you save more people from dying, you save more people from illness, or any other consequence you consider of value.

PROPOSED JOHN E. FOGARTY INTERNATIONAL CENTER FOR ADVANCED STUDY IN THE HEALTH SCIENCES

Mr. LAIRD. Mr. Secretary, January 18 was the day in the House when we were giving eulogies to the late chairman of this subcommittee, John Fogarty. One of the suggestions which I made on that day was the establishment of an International Center for Advanced Study in the Health Sciences as a memorial to him. I would like to insert those remarks in the record at this point.

(The remarks follow:)

Mr. LAIRD. Mr. Speaker, John Fogarty's deep and devoted interest in international health and his conviction that through international exchange in the

health sciences, a significant contribution could be made not only to the solution of health problems but also to the advancement of world peace is, perhaps, best epitomized in his remarks before a panel on Health for Peace during the meeting of our Citizens Committee for the World Health Organization held in Washington in September 1963. The final paragraph of John's remarks is of particular significance and I should like to quote it here:

"In concluding my remarks I would like to set forth an idea and a view which I feel to be of the greatest importance and significance. Instead of a curtailment of the programs and activities of the United States in the field of international health research, I should like to see a plan to bring into being at Bethesda a great international center for research in biology and medicine dedicated to international cooperation and collaboration in the interests of the health of mankind as so boldly envisaged by the President. This center would encompass conference facilities, laboratory and study space, and living quarters to permit the assembly for discussion, study, and research of the outstanding health scientists of the world. I visualize this center associated with the great facilities of the National Institutes of Health and the National Library of Medicine as representing the visible and tangible embodiment of this Nation's devotion to the use of science for peaceful purposes and the good of mankind."

I can think of no more fitting and lasting tribute to this great humanitarian, than the establishment by this Congress of such a center—the John E. Fogarty International Center for Advanced Study in the Health Sciences. I have talked with most of the members of our committee about this and they have all been enthusiastic in their support. I am sure that support will be unanimous, both in our committee and in the entire Congress. Not only will such an institution be a living embodiment of the spirit and aspirations of John Fogarty, but it will serve a needed and valuable role in securing the progress of science in the cause of the well being of all mankind.

Mr. LAIRD. The suggestion was to establish at the National Institutes of Health an International Center for Advanced Study in the Health Sciences, this International Center to be named after the former chairman of our subcommittee, John Fogarty. I was advised shortly before the President sent up his health message that this suggestion had been endorsed by the President and would be included in his health message. The health message came to Congress and the information I had received was partially correct, the Center was included as a recommendation of the President, but the name of John Fogarty had been deleted from the recommendation. I was disappointed in that because I felt—and I still feel—that every member of this committee would want to include this recognition of our former Chairman because of his great interest in international health and, even more specifically, in such a center.

There was a special briefing of the press on the President's message and at that briefing a fact sheet was handed out and the fact sheet

almost followed very closely the statement I had made on the floor of the House. It made mention of the fact the Center would be called the John E. Fogarty International Center for Advanced Study in the Health Sciences. In a matter of hours there was apparently a change made in the President's message to delete the name of our late Chairman. I would like to have some explanation of this. I would like to know something about what happened.

Secretary GARDNER. Well, let me just say that I do not know the story behind that. I was told indirectly, with what accuracy I cannot say, that the President felt perhaps it was more appropriate for Congress to decide on the name and the tribute, but I cannot answer the question.

I do want to say that very few times in my life have I been more impressed with the integrity and ability of a man than I was with Chairman Fogarty. Any tribute of any kind to him and his memory would certainly be very well taken by all of my colleagues and myself.

Mr. LAIRD. Thank you, Mr. Secretary. It would be my hope that we give consideration to going forward with the original intent of the Center.

That is all, Mr. Chairman.

SECRETARY'S RESPONSIBILITY FOR DEPARTMENT'S CIVIL RIGHTS POLICY

Mr. FLOOD. Mr. Natcher.

Secretary GARDNER. Mr. Chairman, may I make a brief statement in respect to some of the things we talked about yesterday before we start the questions?

Mr. NATCHER. That is all right, Mr. Chairman, if it meets with your approval.

Mr. FLOOD. Go ahead.

Secretary GARDNER. This will be very brief.

I was deeply concerned over some of the implications of Mr. Natcher's comments yesterday and I would like to make a very brief statement before we examine the specific points that he has raised.

First, Mr. Natcher spoke rather vigorously of the policies pursued by the Commissioner of Education, and I must tell him that every matter of basic policy or principle in our civil rights program has been scrutinized by me and endorsed by me.

It would be a shocking dereliction of duty if I had not given the closest personal attention to basic policy in the most controversial program my Department administers. I have given that personal attention, and take full responsibility for the policies and principles under which we have operated.

Second, in arriving at those principles we may have been wise or unwise, but we have never been arbitrary or capricious. We have checked every point of policy against the legislation, the legislative history, court decisions, and Department of Justice views. We have done so not once but many times, not casually but exhaustively.

In short, Mr. Chairman, we have tried at every stage of policy development to proceed in a deliberate and orderly fashion.

I have with me today Mr. Peter Libassi, who is my Special Assistant for Civil Rights, and he can describe in as much detail as you wish the legal or other background of any aspect of our civil rights policy.

Mr. NATCHER. Thank you, Mr. Secretary.

I think in all fairness your position is the position that a Cabinet official should take in regard to one of his Department heads, and I want you to know I think your statement concerning endorsement of the acts and regulations issued and the requirements made by the Commissioner of Education is as it should be.

AUTHORITY TO DESEGREGATE SCHOOL FACULTIES

Mr. Secretary, if you will recall yesterday I pointed out to you that in my opinion neither you nor the Commissioner of Education has any right to go into any State in the United States and say to a superintendent of schools or any school official that teachers must be assigned to a school according to color. I know of no decision of the Supreme Court that gives you that right. Further, I know that Congress has passed no law giving you this right. And I say to you that as far as the requirements now made by the Commissioner of Education to the 11 States is concerned, that I think he is wrong, and he has no authority to proceed as he is doing at this time.

We further discussed, as you will recall, the recently announced action of the Commissioner of Education concerning the directive that he had sent into 11 States. The thing that concerns me at this particular point is why he did not send this same document into 50 States. He had just as much right to send it into all 50 as he did to send it into 11.

Mr. Secretary, we discussed the provisions of the Civil Rights Act of 1964 showing just what Congress did so that there would be no misunderstanding. Title IV, section 401 of the act says:

"Desegregation" means the assignment of students to public schools and within such schools without regard to their race, color, religion, or national origin.

Mr. Secretary, you will further recall yesterday questions by my friend and colleague, Mr. Casey of Texas, wherein he asked as to whether or not the President had approved the guidelines that we had discussed and I believe your answer was no. In addition to that, when the question was propounded as to the directive and letter recently sent out by the Commissioner of Education to the 11 States, as to whether this had been approved by the President, your answer was no. I say to you quite frankly, Mr. Secretary, that I am not surprised that your answer was no to these questions because I do not believe the President of the United States would endorse the procedure now being carried out by your Commisioner of Education. Mr. Secretary, you go to any State in the United States, and not just in the South, and when you go into the school and inquire as to how many colored students they have in the school and they say they have 50; and you inquire as to how many white students they have and they say 200. You inquire as to the number of families in the community percentage-wise and they say 6 percent of the people in that school district are colored.

You ask the question as to whether or not they have freedom of choice to go in that school and register as a student and they say they do. You ask, "Do you have colored students in the school?" They answer, "We do." Nowhere in any law passed by this Congress or in any decision of the Supreme Court are you or the Commissioner of Education given the right to go in that school where the school has been desegregated according to the decision of the Supreme Court in

1954 and say to the superintendent of that school district that they have to assign colored teachers or white teachers to that school.

Mr. Secretary, if I am wrong either you or Mr. Libassi tell me where I am wrong and cite some decision of the Supreme Court.

BIOGRAPHY OF F. PETER LIBASSI

Mr. FLOOD. By the way, do we have a biographical sketch of you? How did you get here? Where were you born?

Mr. LIBASSI. I was born in Brooklyn, N.Y., on April 20, 1930. I attended school in New York City and at Colgate University and Yale Law School.

Mr. FLOOD. What was your class at Yale?

Mr. LIBASSI. 1954. Then I worked for 7½ years with the State government, 2 years as an attorney and 5½ years as a regional director for the State Commission Against Discrimination. I handled problems of housing, employment, public accommodation, and school desegregation. Then I worked 4 years with the U.S. Commission on Civil Rights where I dealt with Federal civil rights policies. I left the Civil Rights Commision in January 1966 to accept the position with the Department of Health, Education, and Welfare as special assistant to the Secretary.

Mr. FLOOD. How old are you?

Mr. LIBASSI. I am 36.

Mr. FLOOD. Thank you.

We will insert the prepared biographical information at this point.

(The information follows:)

BIOGRAPHIC INFORMATION, F. PETER LIBASSI

January 1966 to present: Special Assistant to the Secretary of HEW for Civil Rights

1962 to May 1965: U.S. Commission on Civil Rights

1965: Deputy Staff Director

1964–1965: Director, Federal Programs Division

1962–1963: Deputy Director, Liaison and Information Division

1956–1962: Regional Director, N.Y. State Commission for Human Rights, Albany, New York

1954–1956: Enforcement Attorney, N.Y. State Housing and Rent Commission, New York, N.Y.

Education:

1951, Colgate University, Hamilton, New York, B.A. Cum Laude; Honors in Political Science

1954, Yale Law School, New Haven, Connecticut, LL.B.

Awards, honors, etc.: Meritorious Service Award, U.S. Commission on Civil Rights.

Personal: Married; three children.

Mr. NATCHER. Mr. Libassi, I will be glad to hear from you at this time.

Mr. LIBASSI. Title VI of the 1964 Civil Rights Act is the basic document on which all of this is predicated. The legislative history is clear in that regard, that title VI was intended to prevent any unconstitutional actions by recipients of Federal funds.

Mr. NATCHER. Just to save a little time, I want you to know that I agree that statement is correct. I further want you to know that I do not believe in second-class citizens. I believe the Civil Rights Act should be fully complied with not only in the 11 States you sent the directive to but in all the States. I agree with that. You do not have to give me that background.

Mr. LIBASSI. All right. There are three basic cases on faculty desegregation. The first is the second *Brown* case.

Mr. FLOOD. Do you have the citation?

Mr. LIBASSI. I will get that for the record.

(The citation is as follows:)

Brown v. *Board of Education of Topeka, Kansas*, 349 U.S. 294 (1955).

Mr. NATCHER. When you mention the cases, please tell us what court.

Mr. LIBASSI. I will try to do that. The information I do not provide here I will supply.

Mr. NATCHER. And the year of the decision.

Mr. LIBASSI. In the second *Brown* decision the court said that the reallocation of the faculty was one of the reasons why they had to allow for deliberate speed and not immediate and complete desegregation of the school systems. That was in 1955. Then there were two more recent Supreme Court cases, *Bradley* v. *City of Richmond*, and *Rogers* v. *Paul*. *Rogers* v. *Paul* is a 1965 decision.

(The citations are as follows:)

Bradley v. *City of Richmond*, 382 U.S. 103 (1965).
Rogers v. *Paul*, 382 U.S. 198 (1965).

Mr. FLOOD. How did the court vote?

Mr. LIBASSI. I believe in the *Bradley* v. *City of Richmond* case in 1965 it was a unanimous decision. The vote on the *Rogers* v. *Paul* decision was also unanimous. In both of those cases the lower courts had held that faculty desegregation was not a question that could be raised in a school desegregation program.

Mr. NATCHER. In a school desegregation program. If you explain this to the committee you and I may be in agreement as to what the decisions held. In any school in the United States you go into a school that is desegregated, has been desegregated, where they have freedom of choice, where any student regardless of race, color, or creed can walk through the door and register if they live in that district, and it complies with the law where the school is completely desegregated and the students have freedom of choice. Then do you have the right to go in that school and say, "We will not approve the elementary and secondary school funds for this school because you do not have enough white teachers or do not have enough colored teachers"? What decision holds that?

Mr. LIBASSI. There is clear legal precedent for the proposition in the circuit courts that a school desegregation program which allows for freedom of choice must operate effectively in eliminating a dual school system, that just affording students a freedom of choice does not eliminate the dual school system, and that any child may raise the point of faculty desegregation in the courts and that the assignment of faculty according to race violates their rights.

Mr. FLOOD. Violates their rights?

Mr. LIBASSI. Yes, that segregation of faculty members is a violation of their rights. That is in the decisions in the *Rogers* v. *Paul* case and in the *Bradley* v. *City of Richmond* case.

Mr. NATCHER. And the test in those decisions was as to whether or not the schools had been desegregated? Is not that the question in-

volved, as to whether or not the school was a desegregated school? Where a school is desegregated and there is no question about that, where you have 2,000 students and 1,500 of them are white and 500 of them are colored, if the colored students in that part of the city go to that school, do you mean to say that existing law provides you can go in and make them asign teachers?

Mr. LIBASSI. No, sir.

Mr. NATCHER. Then your Commissioner of Education is wrong.

GUIDELINE ON FACULTY DESEGREGATION

Mr. LIBASSI. No, because the Commissioner's ruling on faculty desegregation only applies to schools that have not completed the elimination of the dual school system. Where they have eliminated the dual school system the Commissioner does not require the assignment across racial lines. This last year between March 1966 and March 1967 we had 230 school districts in the South that eliminated the dual system completely. They are no longer subject to the guidelines on faculty desegregation. The guidelines on faculty desegregation only apply where a school system is still maintaining separate schools for whites and Negroes and is still in transition in desegregation.

Mr. CASEY. Would you put in the record the 11 States where this letter went?

Mr. LIBASSI. I will get it for the record, yes.

(The information follows:)

The eleven States which received the letter are as follows: Alabama, Arkansas, Georgia, Florida, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, Texas, and Virginia.

TEST FOR DUAL SCHOOL SYSTEMS

Mr. CASEY. And further do you take the position that these 11 States are still operating dual school systems?

Mr. LIBASSI. There are some districts in each of these States that are still operating dual school systems. The dual school system has been eliminated almost completely in the border States. There are 11 States where the number of dual school systems is sizable.

Mr. CASEY. Will you tell me your test in the operation of a dual system?

Mr. LIBASSI. The test we use is whether or not the schools are identifiable in the community as schools intended for the race, either Negro or white. There is no test or rule that is uniform. They are applied in the light of the circumstances in the community. But where they have eliminated the identifiability of race and have assigned students without regard to their race it eliminates the dual system. There is not a fixed number of faculty members that must be assigned.

Mr. CASEY. I just wonder how you determine that. I know in many cities you have a lot of schools that are 100 percent attended by colored because that is where they live and the school does not say "colored school" on it, it has the name of a prominent educator.

Mr. LIBASSI. If a school district develops a plan of assigning children to a school according to geography and the children turn out to be all Negroes, that school is considered in compliance with the guide-

lines of the Commissioner of Education. If they draw a residential zone that is not gerrymandered——

Mr. CASEY. As I understand it, all people in Texas have freedom of choice whether they live in that district or not. If they decide a certain school is a better one for their children and it is across town they can send their children there. I know of a school in Austin that is required each year to send a letter advising that they have this freedom of choice. I am told that. They would like not to have to do this each year. They would like your Department to say, "You sent this letter for three years, you do not have to send it any more." I am told this is a prerequisite to their getting aid, to send this letter.

Mr. LIBASSI. Austin is operating under a voluntary plan for desegregation approved by the Commissioner of Education. As long as a school district wants to operate under a freedom of choice plan HEW requires them to affirm that each year.

Mr. CASEY. By letter?

Mr. LIBASSI. Yes.

Mr. CASEY. For how long?

Mr. LIBASSI. Until they have eliminated the pattern of Negro and white schools in the community. If they feel they have eliminated the dual school system in the district, then they can apply to be relieved of this responsibility.

Mr. CASEY. You say if they feel, but what if you don't feel? The Commissioner says it is all voluntary unless it does not please you all then they set up their budget and they do not have the money and you have them in a vise.

Mr. LIBASSI. Congress requires the Department to be sure the schools are operating on a constitutional basis. If a judgment of the Commissioner is questioned, the school has a right to judicial review of the decision and the Federal funds could be continued while the matter is pending in court.

Mr. CASEY. Did the court say they must send that letter?

Mr. LIBASSI. In Austin? No. They are not under a court order. They are under a voluntary plan approved by the Commissioner. District courts in the Fifth Circuit have held it was valid to require the letters to be mailed.

Mr. CASEY. The public certainly should be well informed after 3 years of it.

Mr. LIBASSI. Any time the district wishes to abandon the process of freedom of choice, which was really developed as a means of desegregation of schools, it may do so. Most schools are not operating on a freedom-of-choice basis. Freedom of choice was developed as an innovation and communities that find it a burden are encouraged to develop any other plan to meet the objectives of title VI.

Mr. CASEY. This freedom of choice is fine. I think it is great. In fact I wish they had had it sometime earlier because you will find different schools are a little better caliber, where the instruction is better and the discipline is better, and I would have liked to have sent my children to such a school. Getting down to this freedom of choice, if a school has the freedom of choice system for students you are not happy because you want them to go further and encourage somebody to do it in regard to schoolteachers. If the teachers won't move you want to tell the school to go in and encourage and ask for

volunteers, and you stop at that point because you say, "I don't know what else you will have to do but you have to do it on a voluntary basis."

Mr. LIBASSI. I think that question gets at the very heart of what was a great deal of the misunderstanding in this case last fall.

Mr. CASEY. It still is right now. You say you do not tell them what to do—"You do it on a voluntary basis but you do it or else you do not get the money." That does not sound voluntary to me.

Mr. LIBASSI. The problem is that the Court and the Department of Justice are very clear that the object of the *Brown* decision was not to afford a few Negro children the choice of going to a white school. The object of the *Brown* decision and decisions that followed was to require the abolition of separate schools for white children and Negro children.

If a district wishes to achieve that objective by freedom of choice, it may do so provided the freedom-of-choice plan is effective. If the freedom-of-choice plan is not effective, then the school district is required to come up with a different plan, one which involves the assignment of children without regard to their choice in order to begin the process of eliminating the dual school system.

ATTORNEY GENERAL'S LETTERS TO CONGRESSMAN HOWARD SMITH AND SENATOR LONG

If I may, there are two letters from the Attorney General, one to Congressman Howard W. Smith, chairman of the Rules Committee, and another letter from the Attorney General to Senator Long, both on the issue of faculty desegregation, citing the Court decisions that were the basis for it.

The letter of the Attorney General stated:

Title VI not only permits the Department to require faculty desegregation, but obliges them to do so as a condition for continued federal financial support.

Mr. NATCHER. With your permission, Mr. Chairman, I would like these two letters placed in the record at this point.

Mr. FLOOD. It is so ordered.

(The letters follow:)

UNITED STATES DEPARTMENT OF JUSTICE,
OFFICE OF THE DEPUTY ATTORNEY GENERAL,
Washington, D.C., October 4, 1966.

Congressman HOWARD W. SMITH,
Chairman, Rules Committee, House of Representatives, Washington, D.C.

DEAR MR. SMITH: During the course of Commissioner Howe's testimony before the Rules Committee on September 30, 1966, the question was raised whether the Department of Health, Education, and Welfare had authority, under the provisions of Title VI of the Civil Rights Act of 1964, to require school districts maintaining dual school systems, in which Negro students and Negro teachers have been assigned to one set of schools and white teachers and white students to another set, to desegregate their faculties as a necessary part of desegregating their school system. You requested that the Department of Justice submit a memorandum to the Committee regarding the applicability of Title VI to such faculty desegregation.

In our judgment, Title VI not only permits the Department of Health, Education, and Welfare to require faculty desegregation, but obliges them to do so as a condition for continued federal financial support under programs administered by that Department.

I will first discuss the scope of the term "discrimination" in section 601 of the Act as it applies to a public elementary and secondary education system. Next,

I will consider the restrictive effect of section 604 of the Act which provides that nothing in Title VI shall be construed to authorize action "with respect to any employment practice."

1. Section 601 of the Civil Rights Act of 1964 provides that "[n]o person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance." This is a clear congressional declaration that discrimination, on the basis of race, against the intended beneficiaries of federal aid programs is unlawful. And it is equally clear that the intended beneficiaries of the programs administered by the Department of Health, Education, and Welfare, granting federal funds to public elementary and secondary school systems throughout the country are the students attending schools in those systems.

The Revised Statement of Policies for School Desegregation Plans under Title VI of the Civil Rights Act of 1964, issued by the Office of Education in March 1966, provides in section 181.13 for the desegregation of faculty and staff as a necessary part of any desegregation plan. The same principle that appears in these revised "Guidelines" was first stated by the Department of Health, Education, and Welfare in its earlier Guidelines of April 1965. The rationale of this provision, as stated in the Revised Guidelines, is that "the racial composition of the professional staff of a school system, and of the schools in the system, must be considered in determining whether students are subjected to discrimination in educational programs." In short, the stated obligation of the school officials to the students is to eliminate all racial aspects of the dual system, including faculty segregation. This view of the obligation is fully supported by the decisions of the Federal courts.

In 1954 the Supreme Court of the United States declared that the segregation of public school students according to race violates the Fourteenth Amendment. *Brown* v. *Board of Education*, 347 U.S. 483 (1954). A year later, the Court, in determining how judicial relief could best be fashioned, mentioned the problem of reallocating staff as one of the reasons for permitting the desegregation process to proceed with "all deliberate speed." *Brown* v. *Board of Education*, 349 U.S. 294, 301 (1955).

Two cases decided by the Supreme Court in late 1965 indicate that school boards may no longer postpone the responsibility owed their students of desegregating faculty. In *Bradley* v. *School Board of Richmond, Virginia*, 382 U.S. 103 (1965), the Court took the view that faculty segregation had a direct impact on a desegregation plan, and that it was improper for the trial court to approve a desegregation plan without inquiring into the matter of faculty segregation. In reaching this conclusion the Court, in a unanimous opinion, commented that "there is no merit to the suggestion that the relation between faculty allocation on an alleged racial basis and the adequacy of the desegregation plans is entirely speculative." And in ruling that there should be no further delay in a hearing on the question of faculty desegregation, the Court further emphasized that "delays in desegregation of school systems are no longer tolerable." 382 U.S. at 105.

In *Rogers* v. *Paul*, 382 U.S. 198 (1965), the Supreme Court extended the undelayed right to challenge teacher segregation to students who had not yet themselves been affected by the School Board's gradual desegregation plan. The Court stated (382 U.S. at 200):

"Two theories would give students not yet in desegregated grades sufficient interest to challenge racial allocation of faculty: (1) that racial allocation of faculty denies them equality of educational opportunity without regard to segregation of pupils; and (2) that it renders inadequate an otherwise constitutional pupil desegregation plan soon to be applied to their grades."

Relying on the *Bradley* case, the Court of Appeals for the Fifth Circuit, the circuit covering the states of Alabama, Florida, Georgia, Louisiana, Mississippi and Texas, ruled in January 1966, in a suit also brought by Negro students, that it was "essential" that the plan of desegregation for Jackson, Mississippi "provide an adequate start toward elimination of race as a basis for the employment and allocation of teachers, administrators, and other personnel." *Singleton* v. *Jackson Municipal Separate School District*, 355 F. 2d 865, 870. The Court of Appeals for the Fourth Circuit, covering Maryland, North Carolina, South Carolina, Virginia and West Virginia, and the Court of Appeals for the Eighth Circuit have similarly ruled in suits brought by pupils in Durham, North Carolina and El Dorado, Arkansas respectively. *Wheeler* v. *Durham City*

Board of Education, No. 10,460 (C.A. 4, July 5, 1966); *Kemp* v. *Beasley*, 352 F. 2d. 14, 23–24 (C.A. 8, 1965). In the *Wheeler* case, the Court stated (slip opinion, p. 4):

"We read the [*Bradley*] decision as authority for the proposition that removal of race considerations from faculty selection and allocation is, as a matter of law, an inseparable and indispensable command within the abolition of pupil segregation in public schools as pronounced in *Brown* v. *Board of Education*, *supra*, 347 U.S. 483. Hence no proof of the relationship between faculty allocation and pupil assignment was required here. The only factual issue is whether race was a factor entering into the employment and placement of teachers."

The Court in *Wheeler* went on to require (at p. 6):

"Vacant teacher positions in the future . . . should be opened to all applicants, and each filled by the best qualified applicant regardless of race. Moreover, the order should encourage transfers at the next session by present members of the faculty to schools in which pupils are wholly or predominantly of a race other than such teacher's. A number of the faculty members have expressed a willingness to do so. Combined with the employment of new teachers regardless of race, this procedure will, within a reasonable time, effect the desegregation of the faculty."

Numerous district courts, in applying the law as elucidated by the Supreme Court and the courts of appeals of their various circuits, have entered orders in school desegregation cases requiring the desegregation of faculty and staff. Citations to these cases and excerpts from the orders entered are set forth in an enclosure to this letter.

In entering faculty desegregation orders, a few of the district courts have also set forth their reasons in memorandum opinions. One such opinion was issued by the United States District Court for the Eastern District of Virginia, in refusing to approve a plan submitted by the School Board of Greensville County, Virginia, on the ground that the plan must, but failed, to include a provision for the employment and assignment of staff on a nonracial basis. *Wright* v. *County School Board of Greensville County, Virginia*, 252 F. Supp. 378 (E.D. Va. 1966). In holding that a faculty desegregation provision approved by the Commissioner of Education was not sufficient, the court stated (at 384):

"The primary responsibility for the selection of means to achieve employment and assignment of staff on a nonracial basis rests with the school board. . . . Several principles must be observed by the board. Token assignments will not suffice. The elimination of a racial basis for the employment and assignment of staff must be achieved at the earliest practicable date. The plan must contain well defined procedures which will be put into effect on definite dates. The board will be allowed ninety days to submit amendments to its plan dealing with staff employment and assignment practices."

The United States District Court for the Western District of Virginia, in providing for similar relief in the case of *Brown* v. *County School Board of Frederick County*, 245 F. Supp. 549, 560 (1965) said:

[T]he presence of all Negro teachers in a school attended solely by Negro pupils in the past denotes that school a 'colored school' just as certainly as if the words were printed across its entrance in six-inch letters."

The decisions of the Federal courts which I have referred to, and the many additional orders synopsized in the enclosure to this letter, establish, I believe, that allocation of faculty upon the basis of race affects a racial discrimination against the students. Absent a clear and specific expression by Congress to the contrary, it should not be assumed that Title VI of the Civil Rights Act of 1964 was intended to exclude this important aspect of racial discrimination that has been traditional to segregated school systems.

2. The suggestion that section 604 of the 1964 Act precludes application of section 601 to the hiring and allocation of public school faculty on the basis of race is inconsistent with the legislative history of Title VI and is contrary to the normal rules of statutory construction.

Section 604 provides that "[n]othing contained in this title shall be construed to authorize action under this title by any department or agency with respect to any employment practice of any employer . . . except where a primary objective of the federal financial assistance is to provide employment."

In enacting Title VI the chief concern of the Congress was to prevent discrimination against the beneficiaries of federally-supported programs. See Hearings, H.R. Comm. on Rules, H.R. 7152, 88th Cong., 2d Sess. (1964), pp. 94, 226; 110

C.R. 6544–46 (Senator Humphrey). After the language of what is now section 601 had been proposed to assure against such discrimination, the desirability of additional clarifying language was suggested to make it clear that discrimination in certain employer-employee relationships, not affecting the intended beneficiaries of the program, would be excluded from the reach of the statute. For example, question had arisen regarding whether the bill's language would forbid a farmer who was receiving benefits under the Agricultural Adjustment Act from discriminating upon the basis of race in the selection of his employees. Hearings, H.R. Comm. on Rules, H.R. 7152, 88 Cong., 2d Sess., 1964, p. 94; 110 C.R. 6545 (Senator Humphrey). The addition of section 604 to the bill as originally proposed clearly excluded the application of the Act to this type of situation.

The racial allocation of teachers in a segregated school system presents a situation patently different from that of racial discrimination in hiring by a farmer receiving federal farm benefits. The assignment of teachers to particular schools could be a most effective means of practicing racial discrimination against students who are the intended beneficiaries of a federally-supported educational program. Surely, if a school district pursued an official policy of assigning teachers with Class "A" teaching certificates only to schools attended by white students the discrimination against the Negro students would be obvious. Congress could hardly have intended by the language of section 604 to exclude such a gross discrimination from the reach of the statute, particularly in light of the specific reference made by Senator Humphrey that Title VI, as it passed the House, would reach teacher segregation. As floor manager of the bill in the Senate, the Senator said (110 C.R. 6545):

"[T]he Commissioner might also be justified in requiring elimination of racial discrimination in employment or assignment of teachers, at least where such discrimination affected the educational opportunities of students. See *Board of Education* v. *Braxton*, C.A. 5, Jan. 10, 1964, 32 U.S. Law Week 2353.

"This does not mean that title VI would authorize a Federal official to prescribe pupil assignments, or to select a faculty, as opponents of the bill have suggested. The only authority conferred would be authority to adopt, with the approval of the President, a general requirement that the local school authority refrain from racial discrimination in treatment of pupils and teachers, and authority to achieve compliance with that requirement by cutoff of funds or by other means authorized by law."

The conclusion that the original purpose of including faculty desegregation was not affected by the addition of section 604 is further strengthened by portions of the legislative history emphasizing that the added section was not intended to affect the substance of section 601. For instance, Senator Humphrey, in introducing the Dirksen-Mansfield substitute, which added section 604, said that "[t]his provision is in line with the provisions of section 602 and serves to spell out more precisely the declared scope of coverage of the title." In the same speech he stated (110 C.R. 12714):

"We have made no changes of substance in Title VI. . . . We have made several minor adjustments and, in addition, we have modified the language to make explicit the declared intention of this title."

The fact that the language of section 604 is worded broadly enough to reach all employment discrimination does not justify defeating the basic and overriding purpose of Title VI. The ordinary rule of statutory construction is that exceptions or exemptions in a statute should be narrowly construed so as not to defeat the primary purpose of a statute. *United States* v. *McElvain*, 272 U.S. 633, 639 (1926); *Spokane & Inland Empire R. Co.* v. *United States*, 241 U.S. 344, 350 (1916); *Korherr* v. *Bumb*, 262 F. 2d 157, 162 (C.A. 9, 1958).

For the foregoing reasons we conclude that section 601 applies to the desegregation of faculty and staff of school systems that have been racially segregated, and that section 604 does not preclude such application.

Sincerely,

RAMSEY CLARK,
Deputy Attorney General.

MARCH 2, 1967.

Hon. RUSSELL B. LONG,
Chairman, Finance Committee,
United States Senate,
Washington, D.C.

DEAR SENATOR LONG: During the course of Secretary Gardner's testimony before your Committee on February 23, 1967, you raised the question whether

the Supreme Court's decision in the *Brown* case requires the desegregation of a public school faculty in which teachers have previously been assigned on a racial basis as part of a dual racial public school system. You asked that this Department furnish the Committee a memorandum discussing the case law in this area. The case law, I believe, clearly imposes on public school authorities the affirmative, constitutional duty to desegregate their faculties so that the rights of pupils to the "equal protection of the laws" under the Fourteenth Amendment will no longer be denied.

In 1954 the Supreme Court of the United States declared that the segregation of public school students according to race violates the Fourteenth Amendment. *Brown* v. *Board of Education*, 347 U.S. 483 (1954). A year later, the Court, in determining how judicial relief could best be fashioned, mentioned the problem of reallocating staff as one of the reasons for permitting the desegregation process to proceed with "all deliberate speed." *Brown* v. *Board of Education*, 349 U.S. 294, 301 (1955).

Two cases decided by the Supreme Court in late 1965 indicate that school boards may no longer postpone the responsibility owed their students of desegregating faculty. In *Bradley* v. *School Board of Richmond, Virginia*, 382 U.S. 103 (1965), the Court took the view that faculty segregation had a direct impact on a desegregation plan, and that it was improper for the trial court to approve a desegregation plan without inquiring into the matter of faculty segregation. In reaching this conclusion the Court, in a unanimous opinion, commented that "there is no merit to the suggestion that the relation between faculty allocation on an alleged racial basis and the adequacy of the desegregation plans is entirely speculative." And in ruling that there should be no further delay in a hearing on the question of faculty desegregation, the Court further emphasized that "delays in desegregation of school systems are no longer tolerable." 382 U.S. at 105.

In *Rogers* v. *Paul*, 382 U.S. 198 (1965), the Supreme Court extended the undelayed right to challenge teacher segregation to students who had not yet themselves been affected by the School Board's gradual desegregation plan. The Court stated (382 U.S. at 200):

"Two theories would give students not yet in desegregated grades sufficient interest to challenge racial allocation of faculty: (1) that racial allocation of faculty denies them equality of educational opportunity without regard to segregation of pupils; and (2) that it renders inadequate an otherwise constitutional pupil desegregation plan soon to be applied to their grades."

Relying on the *Bradley* case, the Court of Appeals for the Fifth Circuit, the circuit covering the states of Alabama, Florida, Georgia, Louisiana, Mississippi and Texas, ruled in January 1966, in a suit also brought by Negro students, that it was "essential" that the plan of desegregation for Jackson, Mississippi "provide an adequate start toward elimination of race as a basis for the employment and allocation of teachers, administrators, and other personnel." *Singleton* v. *Jackson Municipal Separate School District*, 355 F. 2d 865, 870. And in a case decided in August 1966, the same Court ruled that the plan of desegregation for Mobile, Alabama "must be modified in order that there be an end to the present policy of hiring and assigning teachers according to race by the time the last of the schools are fully desegregated for the school year 1967-68." *Davis* v. *Board of School Commissioners of Mobile County*, 364 F. 2d 896, 904.

The Courts of Appeals for the Fourth Circuit (Maryland, North Carolina, South Carolina, Virginia and West Virginia), the Eighth Circuit (Arkansas, Iowa, Minnesota, Missouri, Nebraska, North Dakota and South Dakota) and the Tenth Circuit (Colorado, Kansas, New Mexico, Oklahoma, Utah and Wyoming) have similarly held. In a suit brought by pupils in Durham, North Carolina, the Court stated:

"We read the [*Bradley*] decision as authority for the proposition that removal of race consideration from faculty selection and allocation is, as a matter of law, an inseparable and indispensable command within the abolition of pupil segregation in public schools as pronounced in *Brown* v. *Board of Education*, *supra*, 347 U.S. 483. Hence no proof of the relationship between faculty allocation and pupil assignment was required here. The only factual issue is whether race was a factor entering into the employment and placement of teachers." *Wheeler* v. *Durham City Board of Education*, 363 F. 2d 738, 740 (C.A. 4, 1966).

The Court in *Wheeler* went on to require (at p. 741):

"Vacant teacher positions in the future . . . should be opened to all applicants, and each filled by the best qualified applicant regardless of race. Moreover, the order should encourage transfers at the next session by present members of the faculty to schools in which pupils are wholly or predominantly of

a race other than such teacher's. A number of the faculty members have expressed a willingness to do so. Combined with the employment of new teachers regardless of race, this procedure will, within a reasonable time, effect the desegregation of the faculty."

Chambers v. *Hendersonville Board of Education*, 364 F. 2d 189 (C.A. 4, 1966), involved the problem of Negro teachers who lost their jobs when an all Negro school was abolished. The School Board treated them as new applicants. The Court held that this was discriminatory and invalid under the Fourteenth Amendment, stating (at p. 192):

"First, the mandate of *Brown* v. *Board of Education*, 347 U.S. 483 (1954), forbids the consideration of race in faculty selection just as it forbids it in pupil placement. See *Wheeler* v. *Durham City Board of Education*, 346 F. 2d 768, 773 (4 Cir. 1965). Thus the reduction in the number of Negro pupils did not justify a corresponding reduction in the number of Negro teachers. *Franklin* v. *County Board of Giles County*, 360 F. 2d 325 (4 Cir. 1966). Second, the Negro school teachers were public employees who could not be discriminated against on account of their race with respect to their retention in the system. *Johnson* v. *Branch*, 364 F. 2d 177 (4 Cir. 1966), and cases therein cited. . . ."

In a suit brought by pupils in El Dorado, Arkansas, the Eight Circuit Court of Appeals recognized "the validity of the plaintiffs' complaint regarding the [School] Board's failure to integrate the teaching staff. Such discrimination is proscribed by *Brown* and also the Civil Rights Act of 1964 and the regulations promulgated thereunder." *Kemp* v. *Beasley*, 352 F. 2d 14, 22 (1965). The Court elaborated on this theme in *Smith* v. *Board of Education of Morrilton*, 365 F. 2d 770, 778 (1966):

"It is our firm conclusion that the reach of the *Brown* decisions, although they specifically concerned only pupil discrimination, clearly extends to the proscription of the employment and assignment of public school teachers on a racial basis. Cf. *United Public Workers* v. *Mitchell*, 330 U.S. 75, 100 (1947); *Wieman* v. *Updegraff*, 344 U.S. 183, 191–192 (1952). See *Colorado Anti Discrimination Comm'n* v. *Continental Air Lines, Inc.*, 372 U.S. 714, 721 (1963). This is particularly evident from the Supreme Court's positive indications that nondiscriminatory allocation of faculty is indispensable to the validity of a desegregation plan. *Bradley* v. *School Board of the City of Richmond*, supra; *Rogers* v. *Paul*, supra. This court has already said, 'Such discrimination [failure to integrate the teaching staff] is proscribed by *Brown* and also the Civil Rights Act of 1964 and the regulations promulgated therunder.' *Kemp* v. *Beasley*, supra, p. 22 of 352 F. 2d."

In a recent decision of the Eighth Circuit, *Clark* v. *Board of Education of Little Rock School District*, No. 18, 368 (December 15, 1966), the Court required of the Little Rock, Arkansas School Board (slip op., p. 15) a "positive program aimed at ending in the near future the segregation of the teaching and operating staff." The Court stated (slip op., p. 13):

"We agree that faculty segregation encourages pupil segregation and is detrimental to achieving a constitutionally required non-racially operated school system. It is clear that the Board may not continue to operate a segregated teaching staff. *Bradley* v. *School Board of City of Richmond*, 382 U.S. 103 1965). . . . It is also clear that the time for delay is past. The desegregation of the teaching staff should have begun many years ago. At this point the Board is going to have to take accelerated and positive action to end discriminatory practices in staff assignment and recruitment."

The Court then proceeded to outline the essential ingredients which such "action" must include (pp. 13–14):

"First, . . . future employment, assignment, transfer, and discharge of teachers must be free from racial consideration. Two, should the desegregation process cause the closing of schools employing individuals predominantly of one race, the displaced personnel should, at the very minimum, be absorbed into vacancies appearing in the system. *Smith* v. *Board of Educaton of Morrilton School District, No. 32*, supra. Third, whenever possible, requests of individual staff members to transfer into minority situations should be honored by the Board. Finally, we believe the Board make all additional positive commitments necessary to bring about some measure of racial balance in the staffs of the individual schools in the very near future. The age old distinction of "white schools" and "Negro schools" must be erased. The continuation of such distinctions only perpetrates inequality of educational opportunity and places in jeopardy the effective future operation of the entire 'freedom of choice' type plan."

In a suit brought by pupils in Oklahoma City, Oklahoma, the Court of Appeals for the Tenth Circuit recently affirmed a lower court order requiring that by 1970 "there should be the same percentage of non-white teachers in each school as there now is in the system." *Board of Education of Oklahoma City Public Schools, Independent District No. 89* v. *Dowell*, No. 8523 (January 23, 1967), slip op., p. 22, affirming, 244 F. Supp. 971, 977–978 (W.D. Okla. 1965). The District Court had stated (p. 978) that such a requirement provided "for stability in school faculties during the integration process, . . . keying the change to personnel turnover figures indicating that approximately 15% of the total faculty is replaced each year." Although the evidence showed that there was no difference in the quality of performance between the white and non-white personnel in the school system, the Court of Appeals held (p. 22) that where "integration of personnel exists only in schools having both white and non-white pupils, with no non-white personnel employed in the central administration section of the system", there is "racial discrimination in the assignment of teachers and other personnel." Relying on the Supreme Court's decisions in *Bradley* and *Rogers*, the Court stated (p. 22) that "[t]he [lower court] order to desegregate faculty is certainly a necessary initial step in the effort to cure the evil of racial segregation in the school system."

Numerous district courts, in applying the law as elucidated by the Supreme Court and the courts of appeal of their various circuits, have entered orders in school desegregation cases requiring the desegregation of faculty and staff. In entering such orders, a few of the district courts have also set forth their reasons in memorandum opinions. One such opinion was issued by the United States District Court for the Eastern District of Virginia in refusing to approve a plan submitted by the School Board of Greensville County, Virginia, on the ground that the plan must, but failed, to include a provision for the employment and assignment of staff on a nonracial basis. *Wright* v. *County Board of Greensville County, Virginia*, 252 F. Supp. 378 (E.D. Va. 1966). In holding that a faculty desegregation provision approved by the Commissioner of Education was not sufficient, the court stated (at 384):

"The primary responsibility for the selection of means to achieve employment and assignment of staff on a nonracial basis rests with the school board. . . . Several principles must be observed by the board. Token assignments will not suffice. The elimination of a racial basis for the employment and assignment of staff must be achieved at the earliest practicable date. The plan must contain well defined procedures which will be put into effect on definite dates. The board will be allowed ninety days to submit amendments to its plan dealing with staff employment and assignment practices."

The United States District Court for the Western District of Virginia, in providing for similar relief in the case of *Brown* v. *County School Board of Frederick County*, 245 F. Supp. 549, 560 (1965), said:

"[T]he presence of all Negro teachers in a school attended solely by Negro pupils in the past denotes that school a "colored school" just as certainly as if the words were printed across its entrance in six-inch letters."

See also *Kier* v. *County School Board of Augusta County*, 249 F. Supp. 239, 247 (W.D. Va. 1966).

The cases which I have reviewed establish, in my judgment, the constitutional duty of school authorities to disestablish imposed racial segregation of faculties and recognize that this obligation emanates from the principles enunciated in the *Brown* decision.

Sincerely,

RAMSEY CLARK,
Deputy Attorney General.

Mr. NATCHER. I have interrupted you several times, Mr. Libassi.

Is there anything else you want to say to the committee by way of court decisions or explanation of the action of the Commissioner of Education?

SERIES OF COURT DECISIONS ON PERFORMANCE

Mr. LIBASSI. There are a series of court decisions if I may refer to them.

Mr. FLOOD. A series?

Mr. LIBASSI. Yes; on the question of performance, and that is the question which we were just raising.

For instance, again in the case of Bradley versus the city of Richmond, Fourth circuit 1965 decision, the court decided that it is the school board which is under the affirmative duty to take corrective action toward the goal of one integrated school district.

The Court stated:

Affirmative action means more than telling those who have long been deprived of freedom of educational opportunities up to now they have a choice.

(Citation is as follows:)

Bradley v. *City of Richmond*, 345 F. 2d. 310 (4th Cir. 1965).

Mr. LIBASSI. And it goes on. There are others.

The 6th Circuit decision in the case of *Northcross* v. *The Board of Education in the City of Memphis.* The court held:

The pupil assignment law will not serve as a plant to convert a biracial system into a nonracial system. Negro children cannot be required to apply for that to which they are entitled as a matter of right. The burden rests on the school authorities to initiate desegregation. The board should submit some realistic plans for the organization of their schools on a nonracial basis.

(Citation is as follows:)

Northcross v. *The Board of Education in the City of Memphis*, 302 F. 2d. 818 (6th Cir. 1962).

Mr. LIBASSI. Then there is a decision in the *Dowell* v. *The School Board of Oklahoma City Public Schools*, the western district of Oklahoma—10th Circuit recently affirmed this decision—quoting now from the district court:

A school board must adopt policies that would increase the percentage of pupils who are obtaining a desegregated education.

(Citation is as follows:)

Dowell v. *The School Board of Oklahoma City Public Schools* (10th Cir., Civil Action No. 8523, Jan. 23, 1967); affirming, 244 F. Supp. 971 (W.D. Okla., 1965).

Mr. LIBASSI. The 5th Circuit, in the *Singleton School* case, said:

In retrospect the second Brown opinion clearly imposes on public school authorities a duty to provide an integrated school system.

(Citation is as follows:)

Singleton v. *Jackson Municipal Separate School District*, 355 F. 2d 865 (5th Cir. 1966).

Mr. LIBASSI. It is because of these decisions and the opinion of the Attorney General that the Department has required not merely the offering of the freedom of choice to the child, but the offering of the choice if it proves effective in eliminating the dual school system.

If I may, there is another letter from the Attorney General to Senator Russell which discusses this very point.

Mr. FLOOD. What point?

Mr. LIBASSI. The point that a school district freedom-of-choice plan must be effective, and if it is not effective the Department is proper in requiring the school district to adopt a different plan.

Mr. NATCHER. Right at that point, Mr. Libassi, I do not think you and I disagree too much about the discussion that we have had up to this time.

Mr. Chairman, with your permission, I would like to have this letter inserted in the record.

Mr. FLOOD. It is so ordered.

(The letter follows:)

OCTOBER 3, 1966.

Hon. RICHARD B. RUSSELL,
U.S. Senate,
Washington, D.C.

DEAR SENATOR RUSSELL: In your letter of August 29, 1966 you ask to be advised of this Department's position on requiring the transfer of Negro students to predominantly white schools against their expressed wishes. You refer specifically to the case of *Byrd* v. *United States of America, et al.*, in the United States District Court for the Middle District of Georgia.

In the *Byrd* case the plaintiff asserted that the Taylor County Board of Education was transferring six Negro students against their wishes to a school attended by white children, and that such transfers had been directed by the Department of Health, Education, and Welfare. As the stipulation which you enclosed with your letter shows, the proposed action of the Taylor County Board of Education had not been required by any policy or regulation of the Department of Health, Education, and Welfare and was, apparently, due to a misunderstanding on the Board's part.

The method of student assignment which has been traditional in most parts of the country has been by assigning children to neighborhood schools on the basis of geographic attendance zones. This method takes no account of the preference of the student and may well result in his assignment to a school against his expressed wish.

The assignment of students to particular schools upon the basis of the students' choice has, in the main, been an innovation adopted in connection with the desegregation of schools that have previously been segregated upon the basis of race. It has been accepted as a permissible means of desegregation, but courts have made it clear that it can be used only if it is effective in abolishing the dual racial school system. Where community hostility or other pressures preclude a truly free choice, then some other method must be used in converting to a nonracial system.

In two school desegregation cases in which the United States is plaintiff by virtue of the Civil Rights Act of 1964, this Department has alleged that the free choice system of desegregation adopted in Franklin County, North Carolina, and in Calhoun County, Mississippi, have not operated effectively because of community hostility and specific acts of reprisal directed against the families of Negro students choosing to attend formerly all-white schools. In each of these cases we asked the court to order the defendants to take additional steps to assure that students be given an effective free choice, and, if such measures failed, to adopt a geographic system of assigning students to particular schools.

In sum, it has been the position of this Department that the free choice system is a permissible method of desegregation only if it is effective in eliminating the dual system based on race. If it is not effective, then an alternative method of assigning children to particular schools, not based upon the choice of students or their parents, must be adopted.

Sincerely,

NICHOLAS DEB. KATZENBACH,
Attorney General.

DISTRICTS FOR WHICH FACULTY DESEGREGATION GUIDELINES APPLY

Mr. FLOOD. Why was the directive sent only to 11 States?

Mr. LIBASSI. The legislative history of title VI clearly indicated that funds were to be denied to schools that were operating on a basis which was unconstitutional. During the legislative discussion, the case of *Bell* v. *Gary, Ind.*—and I will get that citation. I am sorry I am not adequately prepared with the citations for these cases. But

in the case of *Bell* v. *School City of Gary, Ind.*, the Court held that fortuitous segregation was not a violation of the Constitution.

(Citation is as follows:)

Bell v. *School City of Gary, Indiana*, 213 F. Supp. 819 (N.D. Ind. 1963); affirmed, 324 F. 2d. 209 (7th Cir. 1963); cert. denied, 377 U.S. 924 (1964).

Mr. FLOOD. Fortuitous?

Mr. LIBASSI. Segregation which results from housing patterns or neighborhood patterns in districts which are not gerrymandered, segregation which is not the result of the public school action; that if this is the reason for the segregation, that segregation does not violate title VI.

Senator Humphrey read into the record—this is the legislative history—that title VI would not result in the termination of funds in situations where the school boards had not acted in violation of the Constitution.

Unfortunately, in the 17 Southern States school segregation was a matter of law. I do not mean to imply there is not school segregation in the North which may violate the Constitution. There is some, but it is much more difficult to establish.

Mr. FLOOD. Is it fortuitous?

Mr. LIBASSI. Where it is not fortuitous it would be a violation of the Constitution and title VI.

In the *Taylor* v. *New Rochelle School* case, the Court held the New Rochelle School Board had deliberately segregated the children by gerrymandering the districts and that was held to be unconstitutional.

(Citation is as follows:)

Taylor v. *Board of Education*, 191 F. Supp. 181 (S.D.N.Y. 1961); affirmed, 294 F. 2d 36 (2nd Cir. 1961); cert. denied, 368 U.S. 940 (1961).

Barring the proof of that kind of action, title VI applies basically to the 13 Southern States. For that reason, it was written to the chief State school officers in those States.

Mr. NATCHER. Mr. Libassi, do you agree with me that in my State where they have desegregated schools, freedom of choice, and where the children in the schools have the right to enter and go to school if they desire, and there is complete desegregation, that you have no right to go into that school district or that State and say to the school superintendent that you must change your teachers, must assign more white teachers and more colored teachers? Am I right about that?

Mr. LIBASSI. Yes, you are right.

Mr. NATCHER. Are you not doing the same thing in a number of States right now?

Mr. LIBASSI. No, sir; we are not.

Mr. NATCHER. You are positive of that?

Mr. LIBASSI. Yes, sir. We only require school districts that are proceeding under plans to eliminate the dual school system—we only require those districts to integrate their faculty and assign it across racial lines.

Let me say that faculty segregation and discrimination may be a violation of the Constitution; public officials are not supposed to discriminate. But in the operation of our school desegregation plans we are looking to the problem of faculty desegregation in terms of those that are proceeding under the voluntary plan and have not completely eliminated the dual school system.

Mr. NATCHER. Here is where I think the Commissioner of Education is making a mistake. He is laboring under the misapprehension that he must have a balanced school or a balanced school district, and the law does not say that and none of those decisions do, Mr. Libassi. None of them do. The word the Supreme Court 1954 decision used is "desegregation", and I know you will agree with me that desegregation as set forth in this decision means that students may go to public schools and into all schools without regard to their race, color, religion, or national origin, and that the use of this word "desegregation" shall not mean the assignment of students to public schools in order to overcome racial imbalance, and nowhere do you find a suggestion that teachers may be assigned or shifted according to the wishes of the Commissioner.

Now there is where I fall out with you, and especially with the action of the Commissioner of Education, because busing of students, assignment of teachers and in all of these other moves he is attempting to balance the school and district in violation of the law.

Mr. LIBASSI. No, sir; that is not what the Commissioner of Education is doing. If the Commissioner of Education were attempting to do that, he would be violating the law. We have been very careful in the administration of this program which involves termination of Federal funds. Every one of these proceedings is checked with the Department of Justice. We do not initiate any case until the Department has reviewed the facts and is sure that the proceeding is consistent with the act.

We are not requiring racial balance, we are requiring the elimination of the dual schools. We are not requiring busing as part of the process of eliminating dual school systems. When we use the word "imbalance"—we are referring to imbalance which did not result from any unconstitutional practices. But if you have a school district that is imbalanced because the school district has been violating the Constitution, the legislative history and title VI clearly requires HEW to terminate funds.

I think we have to draw a distinction between imbalance as referred to in title IV, which has not been found to be unconstitutional, and that imbalance which is the result of unconstitutional practices. And the Commissioner of Education has been acting only where the racial separation or segregation or imbalance is the result of the public policies of school officials. We have not moved in any case that would involve us in attempting to dictate to a school system that they ought to achieve a better balance and overcome neighborhood patterns, or to redraw their lines in order to get a better balance. That is not the appeal and not the way in which the program has been administered.

Mr. NATCHER. Do you maintain in the 11 States where the directive has recently gone out that school funds can be held up in all of those States?

Mr. LIBASSI. School funds can be withheld from any school district which, after a hearing before an impartial hearing examiner, and after approval by the Commissioner and the Secretary, and after the 30 days waiting period, is found to have been discriminating or segregating students or denying them the opportunity to participate in the

program. Federal funds can be withheld under title VI from school districts in any of the 11 States or any other State under these circumstances.

BUSING OF STUDENTS

Mr. NATCHER. Do you feel you have the right under existing law and under the decisions of the Supreme Court to require busing of students in any of the 11 States or any State in the United States before the school district is entitled to receive Federal funds?

Mr. LIBASSI. The guidelines only require that where a school district is operating buses for children that it operate those buses without regard to race, and that if they are providing bus routes, they must provide bus routes for all the children to go to the school where they have made a choice.

We have some cases where Negro children have chosen to go to the school and the school district will not run a bus in front of their house to pick them up and take them to school.

Mr. NATCHER. I think maybe you have missed the point.

Do you have the right to go over into the south section of a city and load schoolbuses with children and take them over into the west section of the city to another school?

Mr. LIBASSI. Most of the school districts in the South in the rural areas are doing just that now in order to maintain segregated schools.

Mr. NATCHER. The rural sections?

Mr. LIBASSI. Yes.

Mr. NATCHER. Where they are taking them to the location of the school? Certainly I understand that, Mr. Libassi. That has existed for years.

Mr. LIBASSI. Right.

Mr. NATCHER. Where you have a city school system with schools throughout the city, do you have the right under the law to go into that city and say you have too many white students in this school and we are going to transfer 300 over here from the south side of the city; do you have that right?

Mr. LIBASSI. No, sir; I do not believe we have.

Mr. NATCHER. Have you tried to do that anywhere in any of the States?

Mr. LIBASSI. No, sir; not anywhere in the United States. I think that is one of the issues that came up in the past congressional hearings. Some local school districts have applied to HEW for funds in order to enable them to transport children from certain schools to other schools where they would have an opportunity for a better education, and under the programs of the Office of Education, funds are provided for school districts that wish to make those applications, but the Department has not required any district in the United States to bus children to overcome racial imbalance.

FACULTY DESEGREGATION GUIDELINES

Mr. NATCHER. We have not had an opportunity on this committee to see this directive that the Commissioner of Education has sent into the 11 States. In this directive do you have any language to the effect that at least two white teachers must be assigned to certain schools and two colored teachers to certain schools?

Is that in this directive?

Mr. LIBASSI. Yes, sir; it is.

Mr. NATCHER. What authority do you have to use that number?

Mr. LIBASSI. The court cases on faculty desegregation—and here I have run out of the names of the cases, but I will get these. The court cases have said that there must be extensive faculty desegregation and we are suggesting by a——

Mr. FLOOD. What is extensive?

Mr. LIBASSI. In the eighth circuit court they said:

There must be racial balance in the staff of the individual schools in the very near future.

(Citation is as follows:)

Clark v. *Board of Education of Little Rock School District*, 8th circuit civil action No. 18 368, Dec. 15, 1966.

Mr. NATCHER. For what purpose—to test as to whether or not that school has been desegregated or as to whether or not that school is entitled to Federal funds?

What is the test in that case?

Mr. LIBASSI. The fifth circuit says the test is the same. The court has said the test for Federal funds and the test for conformance to the *Brown* decision is the same. The fifth circuit court applies the same requirements for compliance with the Constitution and the *Brown* decision as HEW is applying for the receipt of Federal funds. So that the two standards are identical.

And we have the 10th circuit that has said:

There should be the same percentage of nonwhite teachers in each school as there now is in the system—

So that the Circuit Court——

(Citation is as follows:)

Board of Education of Oklahoma City Public Schools, Independent District No. 89 v. *Dowell*, No. 8523 (Jan. 23, 1967), affirming 244 F. Supp. 971 (W.D. Okla. 1965).

Mr. NATCHER. Do you have any decision from the Supreme Court that says that?

Mr. LIBASSI. No. The Supreme Court has only ruled there must be faculty desegregation.

Mr. NATCHER. In order for what?

Mr. LIBASSI. In order for the school districts to be in compliance with the Constitution.

Mr. NATCHER. To see whether or not they are desegregated?

Mr. LIBASSI. That is right.

Mr. NATCHER. That is one of the tests that you could make in going into a school system. You go into a school where you have a number of colored teachers, but the majority of the teachers are white, where you have a number of colored students, percentagewise as many as live in that particular section. Can you cut off Federal funds to that school?

Mr. LIBASSI. I am sorry. I think the answer to that question is no. I am sorry I did not quite grasp the point of that question.

Mr. NATCHER. I agree with you and I did not try to trick you or trap you into anything. I agree the answer would have to be no. I think in your zealousness and in your overanxious attitude to show

that the elementary and secondary school legislation is being properly handled, you are stretching the imagination of all of the people in this country and you are not only doing that, but you are misinterpreting the decisions as to just how far you can go. I say that to you frankly.

Mr. LIBASSI. Sir, I have to say that I cannot agree with you. The courts are requiring desegregation at a far more rapid rate for both students and faculties than the Department. The courts themselves have said HEW standards are minimal. The courts are requiring far more faculty desegregation in the cases coming before them.

I realize these are individual cases that are going before the courts and they are making decisions with respect to the facts and not enunciating general policies. But the courts, the eighth circuit, the 10th, and district court cases in Virginia, western district of Tennessee, middle district of Alabama, all are requiring faculty desegregation at a far greater rate than the Department.

Mr. NATCHER. For what purpose?

Mr. LIBASSI. To eliminate the dual school system, and that is the same reason HEW is requiring faculty desegregation, because the rights of the children are violated if faculties are segregated.

WITHHOLDING FUNDS

Mr. NATCHER. I agree with you if you go into a school district and into schools within that district and find no colored students in a school, no colored teachers in an all white school and a number of other conditions existing, that you could say the schools are not desegregated. But when you go into a State and the school districts where that does not exist, you do not have any right to hold up Federal funds.

Mr. LIBASSI. We have only held up Federal funds in some districts. Twenty-five percent of the districts that we have recently taken to hearing had no student desegregation at all, not one Negro child in a white school. In the other 75 percent of these districts, we found less than 2 percent of the Negro children in the districts within desegregated schools some 12 years after the Supreme Court decision. We are not taking cases to hearings to terminate funds where there is extensive student desegregation and we think it is not quite up to our standards. The only cases we are taking are districts which refuse to comply or districts that have no desegregation of students, or less than 2 or 3 percent. It is the most minimal program in terms of fund termination.

Mr. NATCHER. What authority or what court decision can you cite to this committee at this time that has taken place since the passage of the elementary and secondary school bill that provides that school funds may be withheld under the conditions that you have just outlined to the committee?

Mr. LIBASSI. It is the fifth circuit decision.

Mr. NATCHER. At this point in the record, place the style of that case and the State and the information concerning the case.

Mr. LIBASSI. May I make one qualification on this?

Mr. NATCHER. Yes.

Mr. LIBASSI. This was a three-judge court, two judges affirming, one dissenting. The full fifth circuit court on the 10th of this month

reheard the argument in that case. But that is the decision at the present time.

(The information follows:)

In the Fifth Circuit case, the court stated: "The Guidelines, of course, cannot bind the courts; we are not abdicating any judicial responsibilities. But we hold that HEW's standards are substantially the same as this Court's standards. They are required by the Constitution and, as we construe them, are within the scope of the Civil Rights Act of 1964. In evaluating desegregation plans, district courts should make few exceptions to the Guidelines and should carefully tailor those so as not defeat the policies of HEW or the holding of this Court." (*U.S. v. Jefferson County Board of Education*, Fifth Circuit, Civil Action No. 23345 and No. 23331, December 29, 1966, at page 9.)

Mr. NATCHER. Is this the only one that has transpired since the passage of this particular bill or where the question we have been discussing has been decided by any court?

Mr. LIBASSI. There is an Eighth circuit court opinion which said the requirement of faculty desegregation is consistent under the Civil Rights Act of 1964.

(Citation is as follows:)

Kemp v. *Beasley*, 352 F. 2d. 14, 22 (1965)
Smith v. *Board of Education of Morrilton*, 365 F. 2d. 770 (1966)

Mr. NATCHER. Not the Civil Rights Act. Let's go back to the withholding of school funds. That is what I am interested in.

Mr. LIBASSI. There have been no court cases as yet to come after the administrative process where we have terminated Federal funds and the school district has sought judicial review of that decision in the courts. There are some where the parties are represented by the State attorney generals that we do expect will go to court.

The Fifth circuit court decision—may I quote one sentence from it because I think it is very important on this question:

The distinctive feature of these cases consolidated on appeal is that they require us to re-examine school desegregation standards in the light of the Civil Rights Act of 1964 and the guidelines of the U.S. Office of Education, Department of HEW.

So while the Fifth circuit decision did not involve a fund termination issue, the Fifth circuit very clearly reviewed and decided the cases in light of HEW guidelines.

Secretary GARDNER. Mr. Chairman, Mr. Kelly has a point he would like to make to clarify.

Mr. KELLY. I was listening, Mr. Natcher, and I really thought you and Mr. Libassi were agreeing, but he has not gotten the point across.

As I understand, what he is saying about faculty desegregation and numbers applies only to a school district which has not yet reached the point of thinking it is desegregated. This decision is made by the school district. The school district gives us an assurance of compliance with title VI. And if they feel that they are operating a desegregated school system whereby they in no way discriminate because of color, they file a regular assurance form and the test occurs then as to whether they are desegregated or not.

Mr. NATCHER. Is that the pledge you require them to make?

Mr. KELLY. It is an assurance that they are in compliance. But for those school districts that feel they have not yet achieved this, that were operating a dual school system, and that are in the process of dis-

mantling that to a single school system, they are unable to file the assurance that no discrimination will occur. So they file an assurance that they will live up to a plan directed towards bringing about desegregation. And these guidelines only apply to those school districts which of their own volition asked to be allowed to operate under a plan moving toward desegregation because they do not believe they have yet achieved it.

Mr. NATCHER. You mean the directive that is going to the 11 States covers the conditions that you have just described to the committee?

Mr. KELLY. It only applies to those school districts which are operating under a plan and which have not yet decided that they are prepared to say that they are operating a desegregated school system.

Is that not correct?

Mr. LIBASSI. Absolutely correct.

ELEMENTARY AND SECONDARY EDUCATION FUNDS DEFERRED

Mr. NATCHER. Can you give me some idea as to how much of the appropriation for education for elementary and secondary schools is presently being deferred or held up?

Mr. LIBASSI. Yes, I will get that for the record.

Mr. NATCHER. And place it in the record at this point.

Mr. LIBASSI. Yes, sir.

(The information follows:)

Civil rights and title I of the Elementary and Secondary Education Act

Amount appropriated for 1967	$1,053,410,000
Amount of entitlement withheld [1] because of noncompliance with title VI of the Civil Rights Act of 1964	9,470,818
Amount of entitlement deferred [2] because of noncompliance	29,732,648

[1] Hearings have been completed and final decisions reached by hearing examiners, the Commissioner of Education, and the Secretary of Health, Education, and Welfare. School districts involved indicate that they have no immediate plans to meet title VI requirements.

[2] Final decisions have not been made to withhold funds. Rather, funds have been deferred temporarily until acceptable assurances or desegregation plans have been filed and approved by the Commissioner of Education. School districts involved show some evidence of meeting requirements but at this time do not have an acceptable plan.

Mr. NATCHER. How much of your appropriation for elementary and secondary schools is being distributed by formula? Can you give me some idea as to that?

Mr. KELLY. It is about $1.050 billion distributed by formula to counties and school districts.

Mr. NATCHER. Mr. Chairman, you have been exceedingly patient with me and I want you and the other members of the committee to know I appreciate your kindness.

Mr. Secretary, I want to thank you and Mr. Libassi and other members of your staff for answering my questions and discussing this matter with me, but in closing I want you to know this, Mr. Secretary, right from the shoulder. I think you are wrong about it. I think your Commissioner of Education is wrong about it, and I think you have no more right to send that directive into the 11 States than you do sending it into the 50 States.

You ought to go back and take another look at this matter. I think the directive that has recently gone down would be denied by the President of the United States and I say that to you frankly.

Mr. Secretary, as one who believes in desegregation and believes that we should not have second-class citizens in this country, I say

to you that you are doing a whole lot to us and I do not know how much we can take. I say that to you frankly. You are doing a lot to my people and when I say "my people" it is the people of the United States of America, and I do not think you have a right to do it.

Mr. Chairman, thank you very much.

Mr. CASEY. I wonder if they could put a copy of this letter in the record at the point where he lists the 11 States.

Mr. FLOOD. Without objection.

(The letter follows:)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
OFFICE OF EDUCATION,
Washington, D.C., February 1967.

MEMORANDUM FOR SCHOOL DISTRICTS OPERATING UNDER FREE CHOICE DESEGREGATION PLANS

We believe it will help school districts this year if they are more fully informed of the procedures the Office of Education will use in reviewing the operation of "free choice" desegregation plans.

GENERAL PROCEDURE

Each school district with a plan is required to file with the Office of Education by April 15 a report of its anticipated staff and student assignments for next fall. School districts using free choice plans should file the report of their anticipated student assignments within 15 days of the end of the choice period. As soon as we receive the report we will make a preliminary determination of the probable compliance status of the district.

Generally speaking those districts operating under free choice plans which meet the criteria set out below will receive a letter indicating that on the basis of the progress reported they appear to be in compliance with the Act and will require no further review this year. If we later receive information indicating less progress than anticipated or other compliance problems, then a review which looks at all aspects of the desegregation plan may be necessary.

CRITERIA FOR EXEMPTION FROM REVIEW ON THE BASIS OF SPRING REPORTS

Student desegregation

For progress in student desegregation beyond what has been achieved in 1966–67, the criteria for preliminary review are those already set out in Section 181.54 of the guidelines.

It should be noted that the guideline percentages apply only in cases where there is a "sizeable percentage of Negro students." In many districts with a small percentage (e.g., less than 15%–20%) of Negro students more substantial progress in eliminating the dual system than that indicated in Section 181.54 would be expected.

Staff desegregation

Last year school districts requesting a rough guide to expect progress were told that the equivalent of one classroom teacher assigned on a desegregated basis in each school normally would be adequate evidence of a sufficient start on staff desegregation, so that no review would be required. For the coming school year double that degree of progress and staff desegregation in both formerly white and Negro schools would be expected to assure that a plan is operating effectively. It should be recognized, again, that this can only be a very rough measure. For instance, in districts with a few large schools more progress would be expected, and in districts with a great many small schools less might be expected.

Other factors

Other factors that will be considered in making preliminary reviews include: existence of complaints affecting free operation of the plan, existence of small, inadequate segregated schools and other evidence of unequal programs, evidence of building programs which would perpetuate the dual system, and discriminatory transfers in or out of the districts. Factors which might indicate adequate progress despite failure to meet the student and staff criteria above might in-

clude such consideration as the special difficulties presented in school districts where there is a very high percentage of Negro enrollment in the schools (such as 70% or 80% or more).

Districts requiring review

Districts which do not meet the above criteria on the basis of their April 15 reports will be considered to require further review because of probable compliance problems. These will be divided into two groups: (a) those districts whose performance falls substantially below the criteria listed above and (b) those districts coming closer to the above criteria but still requiring review.

Each district in these two groups will be notified of its status, and those in category (a) above will be visited for a review on a priority basis. Districts in category (b) will not be visited immediately and should review their own plans carefully and take every possible step to improve their progress before school opens in the fall. Review of these districts is likely to fall during the school year, and adjustments to achieve compliance are always more of a problem while school is in session.

Summer programs

In addition to the operation of their regular desegregation plans, school districts should be alert to the requirement that their special summer programs cannot be operated on a segregated basis. State officials have responsibility for reviewing carefully the proposals for these programs to make certain that ineligible projects are not approved. A bulletin about the requirements for summer programs is attached.

HAROLD HOWE II,
U.S. Commissioner of Education.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
OFFICE OF EDUCATION,
Washington, D.C., February 8, 1967.

Memorandum for chief state school officers

Subject: Civil Rights Compliance in Summer Programs Operated Under Title I of the Elementary and Secondary Education Act of 1965, as Amended:

I want to remind you that procedures instituted in 1966 governing civil rights compliance in Title I summer programs remain in effect for projects undertaken by local educational agencies in the summer of 1967. The revised Title VI desegregation guidelines, issued on January 1, 1967, repeat the 1966 provision (§ 181.14 (b) (4)):

> All special educational programs, such as preschool, summer school and adult education, and any educational program newly instituted, must be conducted without segregation or any other form of discrimination. Free choice desegregation procedures normally may not be applied to such programs.

More detailed explanations of the responsibilities of State agencies for enforcing this provision are contained in my memoranda of April 25, 1966, and July 1, 1966, on this topic. I urge you to review these documents, as they clearly spell out your responsibilities for assuring that summer programs are operated in a totally desegregated fashion.

The Office of Education attaches great importance to the effective implementation of these procedures. I hope you will remind the local educational agencies in your State of these requirements. In reviewing and approving applications for summer projects, you are requested to review thoroughly with the applicant the procedures that it will follow to assure that the program will be fully desegregated. If projects have already been approved, they should be reviewed again to assure that this requirement is being met. We hope that a careful review at this time will help avoid the necessity of discontinuing or restructuring a project after it has begun.

Title I staff will visit selected State agencies this spring to review with State Title I Coordinators the procedures your agency is following. In the meantime, I hope you will call upon use if we can be of assistance in clarifying any relevant matters.

HAROLD HOWE II,
U.S. Commissioner of Education.

Mr. FLOOD. Mr. Casey, you have some questions on this subject, I suppose. Do you intend to pursue this?

Mr. CASEY. No, I do not believe so. Mr. Natcher has done a good job of covering the subject.

Mr. FLOOD. Mr. Shriver?

NATIONAL TEACHER CORPS

Mr. SHRIVER. I want to ask a few questions related to your formal statement you made in the beginning yesterday morning. You made quite a convincing presentation in behalf of the National Teachers Corps and the members of this committee are familiar with the legislative history of the National Teachers Corps.

Last year the House Appropriations removed the appropriation for the Teachers Corps from our bill and the House went along with that although the Senate restored it, and the conference committee included, it is my recollection, about $9 million with the understanding that this program was being phased out. And this record is all a matter of public record and congressional record. I do not know why but we now, as members of the committee, are receiving mail, I am I know, from a number of teachers in this program, and from districts that are participating in the program. I even had a collect call from a teacher who had some roundabout relationships with my State which was merely a lobbying call to convince me of the need of it. Someone evidently is contacting these people to contact us.

POSSIBILITY OF FUNDING TEACHER CORPS UNDER ESEA TITLE I

My first question is: Why can not this program proceed under title I of the Elementary-Secondary Act?

Secretary GARDNER. Why can it not be funded under title I or why does it have to be a corps?

Mr. SHRIVER. Both.

Secretary GARDNER. First of all, I would think that an item that has aroused as much discussion as this ought to be dealt with separately, and its funding discussed and decided separately. That seems to me the most orderly way to do it, put it up to you as a package and you decide what you want.

RATIONALE FOR "CORPS"

As to whether we should just fund a lot of different teacher training efforts in the schools without having a corps, I tried to address myself to that in my testimony.

First, the whole recruitment process is carried on much more effectively if you have a nationally known body for which you are recruiting. Everybody knows what they are being recruited for, like the Peace Corps.

Second, much of the contribution that these young people bring to the schools is enthusiasm, commitment, and a feeling of being a part of a larger effort. And there is no question that this is very much more enhanced because of the existence of the Corps.

After all, we have had teacher training programs for a long, long time and they have not characteristically generated great enthusiasm.

Mr. SHRIVER. But they have been done by the States where education has traditionally and historically been.

Secretary GARDNER. Yes; that is right.

Mr. SHRIVER. Now we are moving into an area of training of this nature where the Federal Government is doing most of it, we are putting up 90 percent of the money, and you originally wanted 100 percent, and this committee changed the formula.

Secretary GARDNER. Yes, sir; but the Federal Government only recruits. Training is done in the teacher training institutions that have always done teacher training by the same people that have always done teacher training. The youngsters, when they go in under a master teacher into a school, are under the supervision of that school's principal. They can be fired tomorrow, they can be assigned to this job or that job. The whole feedback from the local districts has been satisfaction with this local control. There has been no turbulence about Federal control because the Federal control has not existed. Those youngsters are employees of the school districts. It has worked very well. So that you get the benefits of national recruitment and the esprit that comes from being members of a known group, but you get no Federal control.

Mr. FLOOD. What are the benefits of a national group?

Secretary GARDNER. That these young people, many of whom would not normally go into teaching, can be reached through something that has the atmosphere and the flavor of commitment and public service and a national effort when they could not be reached just by the normal year-in and year-out efforts of people who want to get more teachers.

Mr. SHRIVER. That same argument could be used, could it not, to attempt to fill up the gap and the shortage of anything? So you would have the Federal Government involved in the whole picture.

Secretary GARDNER. I believe the whole history of the Peace Corps and many other services is that you get this morale effect with a small group.

Mr. SHRIVER. Of course you are comparing it with the Peace Corps, with an effort that was Federal in nature, our foreign affairs.

It is my understanding that education has been traditionally and historically a matter for the States and the localities rather than for the Federal Government, particularly with relation to training teachers.

TEACHER CORPS IN RURAL SCHOOL DISTRICTS

You mentioned school districts already involved, over 25 percent are in rural areas. Would you list those rural areas?

Secretary GARDNER. Yes, sir; we will.

Mr. SHRIVER. Are there very many of them?

Secretary GARDNER. Yes.

(The information requested follows:)

Of 111 Teacher Corps projects now in operation, 28 are located in the following rural areas. These areas are regarded as rural because they have a population of 2,500 or less.

Gentry, Arkansas
Menifee, Arkansas
Mayflower, Arkansas
Center Ridge, Arkansas
Wright, Arkansas
St. Joe, Arkansas
Hattiesville, Arkansas
Hardinsburgh, Kentucky
Hernando, Mississippi
Macy, Nebraska
Anthony, New Mexico
Hatch, New Mexico
Murphy, North Carolina
Robbinsville, North Carolina
Sylva, North Carolina
Unaka, North Carolina
Franklin, North Carolina
Konawa, Oklahoma
Ladonia, Texas
De Kalb, Texas
Simms, Texas
Hempstead, Texas
Waller, Texas
Ben Bolt, Texas
Gloucester, Virginia
Hamlin, West Virginia
Wayne, West Virginia
Morovis, Puerto Rico

Mr. SHRIVER. In those States why could not the States have the same kind of a program other than the recruiting possibilities and the glamor of it and getting people that otherwise would not go into teaching? Could this not be done by the States if it is such a fine program and they have had a little demonstration of it? Could they not do it?

Secretary GARDNER. A similar effort could be undertaken by anyone who wanted to do it. College and university student bodies have on occasion set up volunteer efforts of various kinds to go down and help the youngsters in the slums with reading. There are all kinds of things that can be done. But in general none of them have had the impact that this single year of the Teacher Corps has had.

Mr. SHRIVER. It could be funded under title I, too, could it not, for local school districts?

Secretary GARDNER. Presumably yes, sir.

Mr. KELLY. Title I, it seems to me, is a mechanism that can support the qualified teachers in order to increase the attention given to a certain group and so forth. Title I would be a very difficult vehicle to use to organize a program that recruited and trained people to do the job because it is a district by district operation. It would not serve very usefully for the purpose of recruiting and training people. It is pretty largely dependent upon utilizing qualified staffs that already exist.

Secretary GARDNER. If the existing mechanism, which heaven knows is persuasive and well established, if it were pumping qualified teachers into these disadvantaged areas, we would not have this problem. But the plain truth is, as I said yesterday, that the typical pattern for teacher training is that the youngsters in the first place do not get very much actual classroom experience. They spend most of their time sitting on the college campus listening to professors, taking notes. They get a few hours of practice teaching in a fairly well-scrubbed school near the university or college. And this is a very different emphasis. This is focused on the most difficult areas.

This is focused on the areas that teachers are least likely to choose. And these youngsters deliberately say that is where they want to teach.

VOCATIONAL EDUCATION WORK STUDY PROGRAM

Mr. SHRIVER. On page 18 of your statement you are referring to the 1968 budget request which would provide loans for many college students and vocational students. How many students will be provided work-study in the vocational field? How many vocational students?

Secretary GARDNER. 113,000 vocational.

Mr. SHRIVER. You have educational grants and opportunity grants for 285,000 undergraduates and work-study opportunities for 226,000. How about the vocational students?

Mr. KELLY. In fiscal year 1967 there are 35,000 students being aided under the work-study program.

As we discussed with Mr. Laird, the 1968 budget contemplates——

Mr. SHRIVER. That is why that omission?

Mr. KELLY. That will be handled by the Neighborhood Youth Corps and there are no resources in our budget for continuation of that.

PROJECTED NEED FOR HOSPITAL BEDS

Mr. SHRIVER. In your discussion of the health services facilities for hospital construction, which everybody recognizes is a very fine program, how much money do you think is really needed to provide the beds essential over the country?

I know in my own State they are having problems.

Mr. KELLY. We do a survey in which the States advise us how much they would need if there were no limitations and they were able to build all of the facilities that their State plan has identified as being needed. It is a very substantial figure and we can provide that for you.

Mr. COHEN. The estimate for the next 10 years for both hospitals and nursing homes is in the order of magnitude of $10 billion.

Mr. SHRIVER. Would you put the results of the studies in?

Mr. COHEN. Yes.

(The information follows:)

Summary of anticipated construction of hospitals and other medical facilities (under title VI of the Public Health Service Act, 1964 amendments) if there were no limitation on Federal assistance for fiscal years 1968 and 1969

State and fiscal year	Number of projects	Estimated cost (in thousands)		Beds or related health facilities added, by type of facility								
				Number of beds				Number of related health facilities				
		Total cost	Federal share	Total	General hospital	TB hospital	Long-term care facilities	Total	Diagnostic or treatment center	Rehabilitation facility	Public health center	State health laboratory
UNITED STATES AND TERRITORIES												
Total	2,858	$5,536,786	$2,272,696	184,991	129,920	519	54,552	529	250	117	157	5
1968	1,999	3,725,975	1,505,570	126,985	86,765	429	39,791	401	208	96	95	2
1969	859	1,810,811	767,126	58,006	43,155	90	14,761	128	42	21	62	3
Alabama	63	82,862	49,488	3,562	3,184	144	234	10	----	4	6	----
1968	23	19,254	11,323	909	715	54	140	2	----	----	2	----
1969	40	63,608	38,165	2,653	2,469	90	94	8	----	4	4	----
Alaska	7	12,550	5,245	256	176	----	80	----	----	----	----	----
1968	4	5,900	2,420	116	96	----	20	----	----	----	----	----
1969	3	6,650	2,825	140	80	----	60	----	----	----	----	----
Arizona	141	72,575	36,481	1,967	1,434	----	533	101	68	21	12	----
1968	141	72,575	36,481	1,967	1,434	----	533	101	68	21	12	----
1969	----	----	----	----	----	----	----	----	----	----	----	----
Arkansas	44	33,519	13,832	1,626	1,079	----	547	4	----	----	4	----
1968	21	19,124	6,133	617	409	----	208	2	----	----	2	----
1969	23	14,395	7,699	1,009	670	----	339	2	----	----	2	----
California	78	223,194	68,420	5,719	5,284	253	182	14	9	5	----	----
1968	72	189,206	57,317	4,998	4,563	253	182	14	9	5	----	----
1969	6	33,988	11,103	721	721	----	----	----	----	----	----	----

Summary of anticipated construction of hospitals and other medical facilities (under title VI of the Public Health Service Act, 1964 amendments) if there were no limitation on Federal assistance for fiscal years 1968 and 1969—Continued

State and fiscal year	Number of projects	Estimated cost (in thousands)		Beds or related health facilities added, by type of facility								
				Number of beds				Number of related health facilities				
		Total cost	Federal share	Total	General hospital	TB hospital	Long-term care facilities	Total	Diagnostic or treatment center	Rehabilitation facility	Public health center	State health laboratory
UNITED STATES AND TERRITORIES—con.												
Colorado	54	$67,039	$28,917	2,219	1,795	----	424	12	7	1	4	----
1968	54	67,039	28,917	2,219	1,795	----	424	12	7	1	4	----
1969	----	----	----	----	----	----	----	----	----	----	----	----
Connecticut	26	75,230	24,766	2,013	1,383	----	630	7	1	3	3	----
1968	26	75,230	24,766	2,013	1,383	----	630	7	1	3	3	----
1969	----	----	----	----	----	----	----	----	----	----	----	----
Delaware	7	4,825	2,062	215	65	----	150	2	----	2	----	----
1968	4	2,575	1,187	100	----	----	100	2	----	2	----	----
1969	3	2,250	875	115	65	----	50	----	----	----	----	----
District of Columbia	21	81,952	32,401	1,279	529	----	750	3	1	----	2	----
1968	----	----	----	----	----	----	----	----	----	----	----	----
1969	21	81,952	32,401	1,279	529	----	750	3	1	----	2	----
Florida	161	159,792	73,951	10,536	6,323	----	4,213	43	26	9	8	----
1968	158	143,992	67,401	9,815	5,602	----	4,213	43	26	9	8	----
1969	3	15,800	6,550	721	721	----	----	----	----	----	----	----
Georgia	82	98,597	38,381	3,920	2,906	----	1,014	13	1	----	12	----
1968	37	57,296	21,104	2,304	1,796	----	508	5	1	----	4	----
1969	45	41,301	17,277	1,616	1,110	----	506	8	----	----	8	----

Hawaii	16	72,844	36,507	369	238		131	5		1	4	
1968	11	35,498	19,328	323	238		85	3		1	2	
1969	5	37,346	17,179	46			46	2			2	
Idaho	9	10,295	3,784	484	433		51					
1968	4	8,290	2,781	252	236		16					
1969	5	2,005	1,003	232	197		35					
Illinois	111	316,346	117,078	8,101	5,099		3,002	23	8	7	4	4
1968	72	167,786	57,654	4,602	2,386		2,216	17	6	6	3	2
1969	39	148,560	59,424	3,499	2,713		786	6	2	1	1	2
Indiana	26	94,774	31,440	2,245	2,165		80	2	2			
1968	26	94,774	31,440	2,245	2,165		80	2	2			
1969												
Iowa	44	125,400	41,800	3,929	2,109		1,820					
1968	18	55,050	18,350	1,660	1,045		615					
1969	26	70,350	23,450	2,269	1,064		1,205					
Kansas	30	52,515	26,258	3,842	3,353		489	2			1	1
1968	15	19,940	9,970	1,341	1,087		254					
1969	15	32,575	16,288	2,501	2,266		235	2			1	1
Kentucky	71	100,360	51,142	3,910	2,905		1,005	19	11	2	6	
1968	40	37,112	19,037	1,431	886		545	13	7	1	5	
1969	31	63,248	32,105	2,479	2,019		460	6	4	1	1	
Louisiana	19	74,801	36,807	2,258	1,883		375	4		3	1	
1968	12	63,155	31,057	1,934	1,559		375	3		2	1	
1969	7	11,646	5,750	324	324			1		1		
Maine	28	30,110	15,055	1,013	470		543	6	5	1		
1968	17	10,960	5,480	399	201		198	4	4			
1969	11	19,150	9,575	614	269		345	2	1	1		
Maryland	4	21,218	7,031	947	647		300					
1968	4	21,218	7,031	947	647		300					
1969												

Summary of anticipated construction of hospitals and other medical facilities (under title VI of the Public Health Service Act, 1964 amendments) if there were no limitation on Federal assistance for fiscal years 1968 and 1969—Continued

State and fiscal year	Number of projects	Estimated cost (in thousands)		Beds or related health facilities added, by type of facility								
				Number of beds				Number of related health facilities				
		Total cost	Federal share	Total	General hospital	TB hospital	Long-term care facilities	Total	Diagnostic or treatment center	Rehabilitation facility	Public health center	State health laboratory
UNITED STATES AND TERRITORIES—con.												
Massachusetts	54	$146,329	$53,051	3,868	2,758		1,110	2		2		
1968	33	95,641	32,779	2,279	1,619		660	2		2		
1969	21	50,679	20,272	1,589	1,139		450					
Michigan	74	266,090	107,248	8,951	6,061		2,890	5		5		
1968	56	145,090	61,430	5,079	2,989		2,090	4		4		
1969	18	121,000	45,818	3,872	3,072		800	1		1		
Minnesota	119	139,217	59,668	6,026	2,469		3,557					
1968	72	76,034	31,233	3,305	1,301		2,004					
1969	47	63,183	28,435	2,721	1,168		1,553					
Mississippi	20	20,917	13,945	849	849							
1968	20	20,917	13,945	849	849							
1969												
Missouri	55	107,332	55,750	3,870	2,725		1,145	6	4	1	1	
1968	31	46,179	23,967	1,999	1,389		610	4	2	1	1	
1969	24	61,153	31,783	1,871	1,336		535	2	2			
Montana	30	24,461	9,784	879	604		275	1		1		
1968	30	24,461	9,784	879	604		275	1		1		
1969												

Nebraska	35	51,892	20,549	1,863	1,180		683	1	1			
1968	27	35,622	14,041	1,505	905		600	1	1			
1969	8	16,270	6,508	358	275		83					
Nevada	10	20,650	7,943	702	627		75	1			1	
1968	4	17,800	6,623	477	477							
1969	6	2,850	1,320	225	150		75	1			1	
New Hampshire	21	34,138	9,990	1,678	859		819					
1968	18	32,288	9,290	1,608	839		769					
1969	3	1,850	700	70	20		50					
New Jersey	78	113,804	39,827	4,085	2,785		1,300	22	15	4	3	
1968	74	92,309	32,304	3,535	2,235		1,300	21	14	4	3	
1969	4	21,495	7,523	550	550			1	1			
New Mexico	31	18,556	9,253	432	307		125	20	1		19	
1968	7	10,670	5,335	262	262			1	1			
1969	24	7,886	3,918	170	45		125	19			19	
New York	146	691,945	221,031	17,623	11,757	122	5,744	12	2	4	6	
1968	89	389,665	121,421	10,369	5,918	122	4,329	11	2	4	5	
1969	57	302,280	99,610	7,254	5,839		1,415	1			1	
North Carolina	43	147,824	85,919	3,945	3,775		170	6	4	1	1	
1968	21	83,834	46,277	1,939	1,889		50	4	2	1	1	
1969	22	63,990	39,642	2,006	1,886		120	2	2			
North Dakota	22	21,041	8,420	889	501		388					
1968	22	21,041	8,420	889	501		388					
1969												
Ohio	144	353,921	110,011	20,199	7,206		2,993	33	25	8		
1968	89	239,893	73,554	6,789	4,963		1,826	18	14	4		
1969	55	114,028	36,457	3,410	2,243		1,167	15	11	4		
Oklahoma	35	89,267	42,278	2,356	2,277		79	7	4		3	
1968	25	55,367	25,828	1,451	1,372		79	4	3		1	
1969	10	33,900	16,450	905	905			3	1		2	

Summary of anticipated construction of hospitals and other medical facilities (under title VI of the Public Health Service Act, 1964 amendments) if there were no limitation on Federal assistance for fiscal years 1968 and 1969—Continued

State and fiscal year	Number of projects	Estimated cost (in thousands)		Beds or related health facilities added, by type of facility								
				Number of beds				Number of related health facilities				
		Total cost	Federal share	Total	General hospital	TB hospital	Long-term care facilities	Total	Diagnostic or treatment center	Rehabilitation facility	Public health center	State health laboratory
UNITED STATES AND TERRITORIES—con.												
Oregon	46	$59,955	$19,985	1,790	1,156		634	5		1	4	
1968	22	35,445	11,815	1,155	865		290	1			1	
1969	24	24,510	8,170	635	291		344	4		1	3	
Pennsylvania	171	322,155	107,336	11,282	5,270		6,012	21	13	8		
1968	171	322,155	107,336	11,282	5,270		6,012	21	13	8		
1969												
Rhode Island	18	56,357	23,381	690	400		290	3	2		1	
1968	18	56,357	23,381	609	400		290	3	2		1	
1969												
South Carolina	47	78,183	52,122	2,803	2,033		770	13	3	4	6	
1968	18	49,152	32,768	1,790	1,350		440	3	1	2		
1969	29	29,031	19,354	1,013	683		330	10	2	2	6	
South Dakota	30	19,978	7,623	1,499	970		529	3		3		
1968	17	14,651	4,962	954	570		384	3		3		
1969	13	5,327	2,661	545	400		145					
Tennessee	36	19,479	10,202	1,124	493		631	17			17	
1968	21	9,727	5,059	650	345		305	11			11	
1969	15	9,752	5,143	474	148		326	6			6	
Texas	189	288,089	141,962	11,818	10,474		1,344	39	21	9	9	
1968	116	203,325	99,580	8,219	7,143		1,076	27	13	8	6	
1969	73	84,764	42,382	3,599	3,331		268	12	8	1	3	

Utah	39	60,384	27,701	2,344	1,564		780	2			2	
1968	39	60,384	27,701	2,344	1,564		780	2			2	
1969												
Vermont	14	11,649	4,485	548	233		315	2	2			
1968	10	7,569	3,023	378	63		315					
1969	4	4,080	1,462	170	170			2	2			
Virginia	42	114,285	57,981	3,494	3,094		400	11		1	10	
1968	42	114,285	57,981	3,494	3,094		400	11		1	10	
1969												
Washington	27	50,493	12,125	1,032	952		80	5	1		4	
1968	23	40,920	9,539	855	817		38	5	1		4	
1969	4	9,573	2,586	177	135		42					
West Virginia	41	76,706	38,232	2,823	1,697		1,126	3		1	2	
1968	22	37,070	18,414	1,219	632		587	2			2	
1969	19	39,636	19,818	1,604	1,065		539	1		1		
Wisconsin	84	144,503	57,560	6,277	4,144		2,133	12	6	5	1	
1968	39	68,979	27,591	3,108	2,132		976	5	2	2	1	
1969	45	75,524	29,969	3,169	2,012		1,157	7	4	3		
Wyoming	3	7,500	2,500	280,	280							
1968	3	7,500	2,500	280	280							
1969												
Guam	4	6,500	4,333	168	118		50	1	1			
1968	1	1,500	1,000	50			50					
1969	3	5,000	3,333	118	118			1	1			
Puerto Rico	108	162,397	108,655	8,394	6,842		1,552	6	6			
1968	60	144,171	96,512	7,111	5,885		1,226	6	6			
1969	48	18,226	12,143	1,283	957		326					
Virgin Islands [1]												

[1] Not available.

Source: State agency reports to the Public Health Service.

Mr. SHRIVER. I get a lot of letters and I am sure others do about the continuing and growing need for further funding.

You mentioned on page 28 that you are requesting legislation to encourage the States to improve their programs, and to assure that Federal sharing will be equitable.

Maybe you mentioned this earlier, but has legislation been introduced?

Secretary GARDNER. Yes, sir.

Mr. COHEN. Yes, for title XIX, H.R. 5710 has been introduced and hearings are pending before the Ways and Means Committee.

SAVINGS PROGRAM

Mr. SHRIVER. Mr. Kelly, in your discussion yesterday on the construction grant loan program savings effected, we all knew about inflation last year when we were having our hearings, the effects of inflation. And the 1967 bill was not finally passed until October. Why did you not suggest some reductions during the course of the hearings or before it was finally passed rather than now to talk about the savings that have been made?

Mr. KELLY. If we had to do it all over again, I think we would do it much in the same way. We have reduced the inflationary impact of our programs but, for example, we have not eliminated the construction of any hospital. We have said let's not start the construction of so many hospitals in any month as to create a great peak and let's not put too much construction on the market during the same period. But let's continue to identify the project needs, approve the projects, hire the architects, design the projects and build them in somewhat more orderly and slower manner.

If we were to have taken the funds out of the bill, we would have had an ultimate reduction in the number of facilities we built. Under this program of stretchout, we have not decreased the number of facilities we built, we are using a more orderly and a slower process of starting construction. This process will be equally good for providing a stimulant in an antiinflationary period. You can take the same technique and by having continued to design these projects, you can accelerate the number you can start in any given period.

But we were not suggesting, and would not suggest now, that we reduce the total number of projects.

Mr. LAIRD. Will the gentleman yield?

Mr. SHRIVER. Yes.

Mr. LAIRD. We are at the point now according to the testimony of Secretary Fowler and the Director of the Bureau of the Budget before the Ways and Means Committee last week where we are headed for a period of construction slump. You still have funds frozen in this area. The very point you were making is not a valid point if you consider the testimony of the Budget Director and the Secretary of the Treasury before the Ways and Means Committee. Because if you want this to have an impact at the proper time, the funds have to be released now.

IMPACT OF CONSTRUCTION ON ECONOMY

Mr. KELLY. There are two or three kinds of impact that the construction program has.

Mr. LAIRD. I thought you made a very fine statement, Mr. Kelly, but the only thing is that is not the policy of the administration according to what those two high officials indicated.

Mr. KELLY. Let me assure you the administration knows exactly where we stand with respect to this. They are in touch with us, they know what our ability to slow it down and what our ability to accelerate it is, both of which are limited abilities in the handling of this kind of a program.

I do think construction has an economic impact on the economy in several ways. A major impact occurs with respect to the advertising of bids because this is where competition sets in and thus prices are affected. The award of contracts has an effect on the economy because it results in the placing of orders for materials, for subcontracts for equipment to be delivered at a later date.

And the third impact is the employment of people on the site and the disbursement of funds as materials are delivered.

There are these three different kinds of economic impact. And we think one of the major inflationary or anti-inflationary effects of construction occurs during the advertisement of bids. This is the point at which the competitive economy can see the volume of effort which lies before it. This is the point at which different companies place their price on the work which is going to be performed.

But at the moment we are continuing the program exactly the way I outlined it. This is a part of the overall anti-inflationary and cost cutback program.

USE OF CONSTRUCTION PROGRAMS AS AN ECONOMIC TOOL

Mr. LAIRD. Instead of putting the emphasis on getting hospitals needed for sick people, you put the emphasis on using this as an economic tool. This is a humanitarian program, it is to construct hospital beds.

I understand what you are using the program for, but I felt that when we appropriated the funds, we were appropriating them because there was a real need by people for more hospital facilities throughout America.

OVERAPPROPRIATIONS AND SAVINGS

And this brings up a very interesting point here, because this committee has been accused of overappropriating for fiscal year 1967. Even the chairman of the full committee at the full committee meeting the other day pointed out that this subcommittee had made a record of overappropriating. And since the executive branch shows greater savings here, it is apparently proven that this committe overappropriated for 1967.

Now, Mr. Secretary, in connection with this I would like to find out whether these budget estimates that are given to us today are any more reliable than the budget estimate we got last year as far as what is really needed for 1968 is concerned.

I can go through item by item where we went along with the budget estimates last year only to find that you really didn't need it. You have even put funds in reserves for savings under some appropriations where we reduced your budget request for 1967. I do not want to be put in a position again of overappropriating for the Department of

Health, Education, and Welfare. I don't think this committee or this Congress does either.

What is your comment on that?

Secretary GARDNER. You are referring to the budget as a whole or specific items?

Mr. LAIRD. Both.

Secretary GARDNER. You are referring again to these cutback items?

Mr. LAIRD. I am referring again to the fact that we gave you more money than you needed, according to the record.

Secretary GARDNER. Do you really believe that it is inappropriate for the executive branch to keep an exceedingly sharp eye on inflation and concern itself with the possible impact of its own actions when everything that we do will suffer if the value of the dollar is cut?

Mr. SHRIVER. At that point, in the beginning I said that we knew and everybody around Congress knew of the inflationary trend in April, and certainly in September and October when we finalized the bill.

Secretary GARDNER. But you are smarter than we are.

Mr. SHRIVER. You mean you did not know in October and you started these things right after we passed the bill, these so-called savings?

Mr. KELLY. I did not use the term "savings."

Mr. SHRIVER. I thought you did yesterday.

Mr. KELLY. I intentionally used the term that we were primarily involved in an antiinflationary and a slowup activity because the construction program which we are operating will not produce savings. Rather, it will move some of the construction activity into a period where it is hoped that it will be less inflationary. The number of hospital beds that you appropriated funds for are recognized as being needed. We felt that a deferment, which on the average was about 6 weeks, which would keep the price in construction from being bid up to a higher price, would really result in building more hospital beds with the funds you made available rather than less. If we did not so administer this as to smooth out that curve, it was going to make these programs cost more than they would cost if we could hold down the inflationary impact of putting a great many of them on the market at the same time.

I do not believe that there is involved in this issue an overappropriation. I do not believe that there is involved in this construction slowdown issue the appropriation of unneeded funds.

Mr. LAIRD. I am not going to belabor this further. I think the figures speak for themselves and if the record regarding overappropriating for 1967 isn't clear already it will be after we hear the individual items in your budget.

Mr. SHRIVER. I have no further questions.

Mr. FLOOD. Mr. Casey?

Mr. CASEY. No questions, Mr. Chairman.

Mr. FLOOD. All right, gentlemen, it was a good hearing.

Thank you, Mr. Secretary.

We will follow the procedure of the last several years and include in the hearing record the tables and statements you have prepared at our request which cover statistics and program information for matters covering several or all segments of your Department.

(The tables and statements follow:)

PROGRAM INFORMATION

AND

STATISTICS

(173)

History of 1968 Estimate

FOOD AND DRUG ADMINISTRATION

Appropriation	1967 appropriation [1] (a)	1968 estimate to the Department (b)	1968 Department estimate to Bureau of the Budget (c)	1968 President's budget (d)	Difference, col. (d) plus or minus col. (b) (e)	Difference, col. (d) plus or minus col. (c) (f)
Salaries and expenses	$61,500,000	$96,252,000	$82,231,000	$66,749,000	−$29,503,000	−$15,482,000
Buildings and facilities	3,139,000	22,000,000	2,200,000	1,150,000	−20,850,000	−1,050,000
Total, Food and Drug Administration	64,639,000	118,252,000	84,431,000	67,899,000	−50,353,000	−16,532,000
OFFICE OF EDUCATION						
Elementary and secondary education activities	$1,464,610,000	$3,780,462,000	$3,315,912,000	$1,692,000,000	−$2,088,462,000	−$1,623,912,000
School assistance in federally affected areas	439,137,000	476,909,000	466,200,000	439,137,000	−37,772,000	−27,063,000
National Teacher Corps	20,000,000	50,000,000	46,000,000	36,000,000	−14,000,000	−10,000,000
Higher education activities	1,177,251,000	1,682,750,000	1,593,350,000	1,173,194,000	−509,556,000	−420,156,000
Expansion and improvement of vocational education	268,016,000	516,091,000	275,591,000	259,900,000	−256,191,000	−15,691,000
Libraries and community services	146,950,000	275,020,000	252,020,000	165,950,000	−109,070,000	−86,070,000
Educational improvement of the handicapped	[1] 37,900,000	108,000,000	101,000,000	53,400,000	−54,600,000	−47,600,000
Research and training	91,050,000	298,500,000	199,100,000	99,900,000	−198,600,000	−99,200,000
Educational research (special foreign currency)	1,000,000	4,600,000	4,600,000	4,600,000		
Salaries and expenses	32,836,000	62,082,000	47,236,000	40,253,000	−21,829,000	−6,983,000
Civil rights educational activities	8,028,000	37,867,000	37,867,000	30,000,000	−7,867,000	−7,867,000
Arts and humanities educational activities	1,000,000	8,500,000	1,000,000	1,000,000	−7,500,000	
Colleges for agriculture and the mechanic arts	2,550,000	2,550,000	2,550,000	2,550,000		
Promotion of Vocational Education Act of Feb. 23, 1917	7,161,455	7,161,455	7,161,455	7,161,455		
Student loan insurance fund	3,200,000					
Higher education loan fund:						
New obligational authority: Loans	200,000,000	200,000,000	100,000,000		−200,000,000	−100,000,000
Loan funds from participation sales	(100,000,000)	(100,000,000)	(100,000,000)	(200,000,000)	(−100,000,000)	(−100,000,000)
Total loan level	(300,000,000)	(300,000,000)	(200,000,000)	(200,000,000)		
Interest subsidization, new obligational authority	659,000	3,200,000	3,200,000	2,625,000	−575,000	−575,000
Total, new obligational authority, Office of Education	3,901,348,455	7,513,692,455	6,452,787,455	4,007,670,455	−3,506,022,000	−2,445,117,000
VOCATIONAL REHABILITATION ADMINISTRATION						
Grants for rehabilitation services and facilities	$259,060,000	$338,000,000	$324,000,000	$311,550,000	$26,450,000	$12,450,000
Research and training	60,325,000	80,984,000	76,228,000	65,484,000	15,500,000	10,744,000
Research and training (special foreign currency program)	3,000,000	5,000,000	5,000,000	5,000,000		
Correctional rehabilitation study	800,000	800,000	800,000	800,000		
Salaries and expenses	4,869,000	6,663,000	6,558,000	5,621,000	1,042,000	937,000
Transfer from trust funds	(299,000)	(336,000)	(336,000)	(336,000)		
Total, Vocational Rehabilitation Administration	328,054,000	431,447,000	412,586,000	388,455,000	42,992,000	24,131,000

PUBLIC HEALTH SERVICE

Health manpower education and utilization	$149,746,000	$218,210,000	$216,810,000	$170,413,000	−$47,797,000	−$46,397,000
Construction of health educational facilities	160,000,000	219,000,000	219,000,000	203,000,000	−16,000,000	−16,000,000
Chronic diseases	25,208,000	43,302,000	36,065,000	27,942,000	−15,360,000	−8,123,000
Communicable diseases	68,665,000	82,917,000	80,817,000	72,272,000	−10,645,000	−8,545,000
Air pollution	35,561,000	64,185,000	64,185,000	64,185,000		
Urban and industrial health	35,908,000	61,006,000	60,231,000	42,594,000	−18,412,000	−17,637,000
Radiological health	15,895,000	19,279,000	17,641,000	15,087,000	−3,592,000	−1,954,000
Community health services	64,134,000	104,266,000	98,148,000	68,523,000	−35,743,000	−29,625,000
Hospitals and medical care	57,045,000	75,213,000	73,927,000	63,851,000	−11,362,000	−10,076,000
Hospital construction activities	283,319,000	328,835,000	328,835,000	308,357,000	−20,478,000	−20,478,000
National Institutes of Health:						
Biologics standards	8,709,000	9,280,000	9,280,000	8,649,000	−631,000	−631,000
National Cancer Institute	172,768,000	198,580,000	193,058,000	183,356,000	−15,224,000	−9,702,000
National Heart Institute	163,976,000	194,796,000	190,385,000	167,954,000	−26,842,000	−22,431,000
National Institute of Dental Research	28,447,000	32,388,000	31,926,000	30,307,000	−2,081,000	−1,619,000
National Institute of Arthritis and Metabolic Diseases	134,695,000	156,889,000	153,157,000	143,954,000	−12,935,000	−9,203,000
National Institute of Neurological Diseases and Blindness	115,726,000	134,540,000	134,359,000	128,633,000	−5,907,000	−5,726,000
National Institute of Allergy and Infectious Diseases	87,408,000	96,668,000	96,086,000	94,422,000	−2,246,000	−1,664,000
National Institute of General Medical Sciences	146,056,000	167,113,000	163,485,000	160,284,000	−6,829,000	−3,201,000
National Institute of Child Health and Human Development	67,053,000	80,292,000	76,211,000	68,621,000	−11,671,000	−7,590,000
Regional medical programs	45,360,000	202,799,000	140,600,000	64,314,000	−138,485,000	−76,286,000
Environmental health sciences	13,407,000	28,059,000	21,994,000	20,615,000	−7,444,000	−1,379,000
General research and services	71,968,000	101,551,000	98,570,000	81,141,000	−20,410,000	−17,429,000
Grants for construction of health research facilities	56,000,000	115,000,000	100,000,000	35,000,000	−80,000,000	−65,000,000
Total, National Institutes of Health	1,111,573,000	1,517,955,000	1,409,111,000	1,187,250,000	−330,705,000	−221,861,000
Mental health research and services	225,647,000	268,703,000	260,377,000	246,741,000	−21,962,000	−13,636,000
Community mental health resource support	82,081,000	141,575,000	117,075,000	100,168,000	−41,407,000	−16,907,000
National health statistics	9,312,000	10,031,000	9,931,000	9,767,000	−264,000	−164,000
National Library of Medicine	20,254,000	30,279,000	29,279,000	21,162,000	−9,117,000	−8,117,000
Buildings and facilities	18,279,000	110,915,000	29,904,000	10,715,000	−100,200,000	−19,189,000
Scientific activities overseas	10,000,000	18,685,000	18,685,000	18,685,000		
Retired pay of commissioned officers	10,743,000	13,391,000	13,391,000	13,391,000		
Comprehensive health planning and services	123,557,000	145,001,000	145,001,000	143,628,000	−1,373,000	−1,373,000
Office of the Surgeon General, salaries and expenses	7,755,000	10,659,000	11,115,000	9,087,000	−1,572,000	−2,028,000
Total	2,514,682,000	3,483,407,000	3,239,528,000	2,797,418,000	−685,989,000	−442,110,000

ST. ELIZABETHS HOSPITAL

Salaries and expenses (indefinite)	($9,860,000)	($11,398,000)	($9,099,000)	($9,044,000)	(−$2,354,000)	(−$55,000)
Buildings and facilities	2,298,000	10,130,000	9,920,000	1,237,000	−8,893,000	−8,683,000
Total, St. Elizabeths Hospital	2,298,000	10,130,000	9,920,000	1,237,000	−8,893,000	−8,683,000

History of 1968 Estimate—Continued

SOCIAL SECURITY ADMINISTRATION

Appropriation	1967 appropriation [1] (a)	1968 estimate to the Department (b)	1968 Department estimate to Bureau of the Budget (c)	1968 President's budget (d)	Difference, col. (d) plus or minus col. (b) (e)	Difference, col. (d) plus or minus col. (c) (f)
Limitation on salaries and expenses (trust fund)	($600,459,000)	($651,878,000)	($651,878,000)	($635,260,000)	(−$16,618,000)	(−$16,618,000)
Limitation on construction (trust fund)	(43,189,000)	(10,283,000)	(7,710,000)	(634,000)	(−9,649,000)	(−7,076,000)
Payment for military service credits	105,000,000	126,000,000	126,000,000	105,000,000	−21,000,000	−21,000,000
Payment to trust funds for health insurance for the aged	924,050,000	928,592,000	1,001,592,000	906,631,000	−21,961,000	−94,961,000
Social security research (special foreign currency program)		1,000,000			−1,000,000	
Cooperative research or demonstration projects		1,000,000	1,000,000		−1,000,000	−1,000,000
Total, Social Security Administration	1,029,050,000	1,056,592,000	1,128,592,000	1,011,631,000	−44,961,000	−116,961,000

WELFARE ADMINISTRATION

Grants to States for public assistance [2]	$3,981,500,000	$4,240,000,000	$4,240,000,000	$4,240,000,000		
Assistance for repatriated U.S. nationals	460,000	525,000	525,000	525,000		
Bureau of Family Services, salaries and expenses	7,890,000	9,653,000	9,653,000	8,589,000	−$1,064,000	−$1,064,000
Grants for maternal and child welfare	228,900,000	264,000,000	264,000,000	239,320,000	−24,680,000	−24,680,000
Children's Bureau, salaries and expenses [3]	5,331,000	7,088,000	7,088,000	6,485,000	−603,000	−603,000
Juvenile delinquency and youth offenses [4]	8,207,000					
Cooperative research or demonstration projects [5]	3,150,000	3,470,000	3,470,000	4,170,000	+700,000	+700,000
Research and training (special foreign currency program)	1,500,000	2,500,000	2,500,000	1,500,000	−1,000,000	−1,000,000
Office of the Commissioner, salaries and expenses	1,522,000	2,129,000	2,129,000	1,888,000	−241,000	−241,000
Total, Welfare Administration	4,238,460,000	4,529,365,000	4,529,365,000	4,502,477,000	−26,888,000	−26,888,000

ADMINISTRATION ON AGING

Coordination and development of programs for the aging	$10,275,000	$26,461,000	$26,461,000	$18,450,000	−8,011,000	−$8,011,000
Research and training (special foreign currency program)		250,000	250,000		−250,000	−250,000
Total	10,275,000	26,711,000	26,711,000	18,450,000	−8,261,000	−8,261,000

SPECIAL INSTITUTIONS

American Printing House for the Blind	$1,027,500	$1,264,000	$1,264,000	$1,225,000	−$39,000	−$39,000
National Technical Institute for the Deaf	491,000	6,296,000	6,296,000	2,615,000	−3,681,000	−3,681,000
Model Secondary School for the Deaf:						
Salaries and expenses		470,000	470,000	425,000	−45,000	−45,000
Construction		1,030,000	1,030,000	275,000	−755,000	−755,000
Subtotal		1,500,000	1,500,000	700,000	−800,000	−800,000
Gallaudet College:						
Salaries and expenses	2,542,000	3,206,000	3,206,000	2,878,000	−328,000	−328,000
Construction	70,000	3,097,000	3,097,000	2,196,000	−901,000	−901,000
Subtotal	2,612,000	6,303,000	6,303,000	5,074,000	−1,229,000	−1,229,000
Howard University:						
Salaries and expenses	13,534,000	15,852,000	16,069,000	15,300,000	−552,000	−769,000
Construction	3,342,000	24,726,000	24,726,000	23,111,000	−1,615,000	−1,615,000
Freedmens Hospital	6,639,000	6,970,000	6,881,000	6,700,000	−270,000	−181,000
Subtotal	23,515,000	47,548,000	47,676,000	45,111,000	−2,437,000	−2,565,000
Total, special institutions	27,645,000	62,911,000	63,039,000	54,725,000	−8,186,000	−8,314,000

OFFICE OF THE SECRETARY

Salaries and expenses, Office of the Secretary	$5,509,000	$10,162,000	$8,750,000	$8,088,000	−$2,074,000	−$662,000
Transfers from trust funds	(975,000)	(1,518,000)	(1,310,000)	(1,211,000)	(−307,000)	(−99,000)
Salaries and expenses, Office of Field Coordination	1,778,000	2,812,000	2,490,000	2,418,000	−394,000	−72,000
Transfers from trust funds	(1,773,000)	(2,433,000)	(2,120,000)	(2,095,000)	(−338,000)	(−25,000)
Salaries and expenses, Office of the Comptroller	5,292,000	7,416,000	7,061,000	6,842,000	−574,000	−219,000
Transfers from trust funds	(746,000)	(1,079,000)	(1,023,000)	(991,000)	(−88,000)	(−32,000)
Salaries and expenses, Office of Administration	2,253,000	2,835,000	2,816,000	2,547,000	−288,000	−269,000
Transfers from trust funds	(271,000)	(305,000)	(301,000)	(271,000)	(−34,000)	(−30,000)
Surplus property utilization	1,123,000	1,342,000	1,198,000	1,119,000	−223,000	−79,000
Salaries and expenses, Office of General Counsel	1,800,000	2,111,000	2,111,000	1,974,000	−137,000	−137,000
Transfers from trust funds	(1,330,000)	(1,404,000)	(1,404,000)	(1,373,000)	(−31,000)	(−31,000)
Higher education for international understanding	16,525,000	53,375,000	53,375,000	36,525,000	−16,850,000	−16,850,000
Educational television facilities	3,304,000	304,000	304,000	304,000		
Construction, headquarters office building		2,296,000	2,296,000		−2,296,000	−2,296,000
Total, Office of the Secretary	37,584,000	82,653,000	80,401,000	59,817,000	−22,836,000	−20,584,000
Trust funds	(5,095,000)	(6,739,000)	(6,158,000)	(5,941,000)	(−798,000)	(−217,000)

[1] Includes proposed supplementals.
[2] Includes proposed supplementals as included in the President's budget.
[3] Estimates to Department and Bureau of the Budget included 7 positions and $128,000 that was requested as a separate appropriation item, "White House Conference on Children and Youth." The Bureau of the Budget provided for 5 positions and $77,601 for this item to be included in the Children's Bureau salaries and expenses request.
[4] Legislative authority expires June 30, 1967.
[5] The 1968 estimate to the Department and Bureau of the Budget excludes $1,000,000 that was requested as a separate appropriation in the budget of the Social Security Administration but was disallowed. Bureau of the Budget increase represents the allowance to provide for Social Security Administration projects.

Appropriations and Reserves, Fiscal Year 1967

Appropriation title	1967 appropriation [1]	Formal reserves			Total reserves	Explanation
		Savings	For obligation in subsequent years	For other contingencies		
Food and Drug Administration: Buildings and facilities.	$3,130,000	----------	$15,321,854	----------	$15,321,854	Amounts in reserve for future year planning, construction, and equipping of research and field facilities.
Office of Education:						
Expansion and improvement of vocational education.	278,016,000	$177	8,200,000	----------	8,200,177	$8,000,000 appropriated under the Appalachian Regional Development Act will not be obligated until 1968 due to a lesser number of construction projects in 1967 than anticipated. $200,000 for interest payments under the Vocational Student Loan Insurance Act will be obligated in 1968.
Elementary and secondary educational activities.	1,342,410,000	55,000,000	----------	----------	55,000,000	Savings of $55,000,000 is due to no reallotment of funds under title I of Elementary and Secondary Education Act of 1965.
Higher educational activities	413,900,000	----------	13,800,000	----------	13,800,000	$12,000,000 for interest payment under insured loans program (title IV-B, HEA) will not be obligated until 1968. $1,800,000 for educational opportunity grants will not be obligated until 1968 due to lesser number of continuing awards in 1967 than previously estimated.
Higher education facilities construction.	522,744,000	9,023,000	----------	----------	9,023,000	$9,023,000 represents the unobligated balance for construction loans from the 1966 appropriation.
Higher education loan fund	200,000,000	----------	100,000,000	----------	100,000,000	$100,000,000 for title III, construction loans is placed in reserve for obligation in subsequent years.
Research and training	70,000,000	----------	29,088,000	----------	29,088,000	$29,088,000 for the equipment and construction of research facilities will be carried forward into 1968 due to fewer number of construction projects in 1967 than previously anticipated.
Total, Office of Education	3,243,270,000	73,023,177	151,088,000	----------	224,111,177	
Vocational Rehabilitation Administration:						
Grants for rehabilitation services and facilities.	259,060,000	500,000	----------	----------	500,000	Reduction in innovation grants.
Research and training	60,325,000	835,000	----------	----------	835,000	Reduction in research and demonstration grant continuation costs.
Total, Vocational Rehabilitation Administration.	319,385,000	1,335,000	----------	----------	1,335,000	
Public Health Service:						
Buildings and facilities	[2] 18,279,000	----------	----------	$26,177,411	26,177,411	For obligations for construction to be incurred in future years.
Injury control	5,759,000	52,000	----------	----------	52,000	NOTE.—Amounts in reserve result from application of 1967 cost reduction program unless otherwise noted.
Chronic diseases and health of the aged	91,614,000	106,000	----------	----------	106,000	

Community health practice and research.	128,300,000	169,000			169,000	
Communicable disease activities	44,220,000	172,000			172,000	
Control of tuberculosis	21,597,000	30,000			30,000	
Control of venereal diseases	10,593,000	35,000			35,000	
Dental services and resources	9,693,000	89,000			89,000	
Medical care services	10,385,000	33,000			33,000	
Nursing services and resources	25,623,000	1,154,000			1,154,000	
Hospital construction activities	313,525,000		2,500,000		2,500,000	Demonstration health facilities (Appalachia).
Construction of health educational facilities.	160,727,000	5,000			5,000	
Environmental health sciences	24,298,000	224,000			224,000	
Air pollution	35,561,000	996,000			996,000	
Environmental engineering and sanitation	21,963,000	435,000			435,000	
Occupational health	6,592,000	33,000			33,000	
Radiological health	20,895,000	172,000			172,000	
Bureau of State services management fund	(5,514,000)	25,000			25,000	
General research and services, NIH	68,534,000			268,000	268,000	
National Institutes of General Medical Sciences	145,113,000			25,000	25,000	
Biologics standards	7,904,000	108,000			108,000	
National Institute of Child Health and Human Development	64,922,000			1,892,000	1,892,000	
National Cancer Institute	175,656,000			313,000	313,000	
National Institute of Mental Health	264,119,000	156,000			156,000	
National Heart Institute	164,770,000			143,000	143,000	
National Institute of Dental Research	28,308,000			43,000	43,000	
National Institute of Arthritis and Metabolic Diseases	135,687,000			1,552,000	1,552,000	
National Institute of Allergy and Infectious Diseases	90,670,000			164,000	164,000	
National Institute of Neurological Diseases and Blindness	116,296,000			2,482,000	2,482,000	
Regional medical programs	45,004,000	12,000	21,000,000		21,012,000	
NIH management fund	(50,601,000)			465,000	465,000	
Grants for construction of health research facilities	56,000,000		15,000,000		15,000,000	Construction projects to be contracted in future years.
Construction of mental health-neurology research facility	[3]			113,000	113,000	
National health statistics	9,312,000	32,000			32,000	
National Library of Medicine	20,192,000	65,000	7,500,000		7,565,000	Primarily related to construction projects to be constructed in future years.
Office of the Surgeon General, salaries and expenses.	7,858,000	33,000			33,000	
Total, Public Health Service	2,349,969,000	4,136,000	46,000,000	33,637,411	83,773,411	
Saint Elizabeths Hospital: Buildings and facilities.	[4] 2,298,000		8,655,011		8,655,011	For obligations for construction to be incurred in future years.
Total, Saint Elizabeths Hospital	2,298,000		8,655,011		8,655,011	

Appropriations and Reserves, Fiscal Year 1967—Continued

Appropriation title	1967 appropriation [1]	Formal reserves			Total reserves	Explanation
		Savings	For obligation in subsequent years	For other contingencies		
Social Security Administration:						
Limitation on salaries and expenses	($600,459,000)			($17,883,000)	($17,883,000)	Undistributed balance of contingency fund as of Jan. 31, 1966.
Limitation on construction	(43,189,000)		($39,339,000)		(39,339,000)	For construction to be undertaken in future years.
Total, Social Security Administration.	(643,648,000)		(39,339,000)	(17,883,000)	(57,222,000)	
Welfare Administration						NOTE.—Amounts shown in reserve result from application of 1967 cost reduction program unless otherwise noted.
Assistance for repatriated United States nationals.	460,000			40,000	40,000	Appropriation language specifies that these funds may be apportioned only to the extent necessary to provide for requirements not anticipated in the budget estimates.
Bureau of Family Services, salaries and expenses.	7,890,000	$400,000			400,000	
Grants for Maternal and Child Welfare	228,900,000	3,000,000			3,000,000	Health grants for school and pre-school children estimated to be $32,000,000 instead of $35,000,000 for this first full year of operation.
Children's Bureau, salaries and expenses	5,331,000	196,500			196,500	
Juvenile delinquency and youth offenses	8,207,000	34,000			34,000	
Cooperative research or demonstration projects	3,150,000	34,000			34,000	
Office of the Commissioner, salaries and expenses	1,522,000	35,700			35,700	
Total, Welfare Administration	255,460,000	3,714,200		40,000	3,754,200	
Administration on Aging: Coordination and development of programs for the aging	10,275,000	633,000			633,000	1967 cost reduction program.
Gallaudet College:						
Salaries and expenses	2,542,000	12,000			12,000	Planned savings applied to cost reduction in future years.
Construction	70,000		176,520		176,520	For obligations to be incurred in the future for direct construction.
Total, Gallaudet College	2,612,000	12,000	176,520		188,520	
Howard University: Construction	3,342,000		9,747,878		9,747,878	For obligations for construction to be undertaken in future years.

[1] Includes proposed supplementals.
[2] Excludes $28,548,138 available from prior years.
[3] Excludes $3,333,372 available from prior years.
[4] Excludes $10,429,417 available from prior year appropriations, $6,781,011 which is in reserve.

Staffing Detail, Fiscal Years 1966, 1967, and 1968

	1966		1967		1968	
	Positions	Man-years	Positions	Man-years	Positions	Man-years
Food and Drug Administration:						
Salaries and expenses	4,708	3,929	5,080	4,606	5,268	4,884
Certification	266	213	266	241	266	231
Advances and reimbursements	20	8	20	10	20	10
Total, Food and Drug Administration	4,994	4,150	5,366	4,857	5,554	5,125
Office of Education:						
Salaries and expenses	2,170	1,851	2,450	2,248	2,735	2,617
Civil rights educational activities	90	50	92	94	127	119
Advances and reimbursements	20	15	74	72	74	72
Higher educational activities	250	174	260	222	260	224
School assistance in federally affected areas	60	60	60	52	60	53
Total, President's budget	2,590	2,150	2,936	2,688	3,256	3,085
Allocations and allotments (net)	−20	47	−22	−17	−22	−14
Total, Office of Education	2,570	2,197	2,914	2,671	3,234	3,071
Vocational Rehabilitation Administration:						
Salaries and expenses	345	280	412	366	460	422
Research and training	4	1	4	5	4	2
Reimbursements	3	3	5	5	5	5
Total, Vocational Rehabilitation Administration	352	284	421	376	469	429
Public Health Service:						
Health manpower:						
Health manpower education and utilization	630	530	723	669	795	767
Advances and reimbursements	0	5	46	46	46	46
Total, Health manpower	630	535	769	715	841	813
Disease prevention and environmental control:						
Chronic diseases	891	725	983	842	974	870
Communicable diseases	3,156	2,857	3,265	3,178	3,280	3,243
Air pollution	697	630	847	746	1,116	1,021
Urban and industrial health	955	794	1,136	1,010	1,249	1,119
Radiological health	814	796	814	792	814	797
Public Health Service management fund	155	172	171	152	189	172
Trust funds	3	2	5	4	5	4
Advances and reimbursements	557	397	986	832	994	848
Total, disease prevention and environmental control	7,228	6,373	8,207	7,556	8,621	8,074

Staffing Detail, Fiscal Years 1966, 1967, and 1968—Continued

	1966		1967		1968	
	Positions	Man-years	Positions	Man-years	Positions	Man-years
Public Health Service—Continued						
Health services:						
Community health services	583	381	653	584	799	687
Hospitals and medical care	5,969	5,621	6,296	6,100	6,871	6,653
Hospital construction activities	293	271	302	282	313	294
Indian health activities	5,820	5,359	6,232	5,796	6,696	6,266
Construction of Indian health facilities	0	149	0	220	0	336
Allocation to Bureau of Indian Affairs	0	35	0	55	0	H
Public Health Service management fund	73	71	97	84	115	104
Trust funds	0	3	0	4	0	4
Advances and reimbursements	233	162	297	258	326	269
Total, health services	12,971	12,052	13,877	13,383	15,120	14,670
National Institutes of Health:						
General research and services, National Institutes of Health	308	215	329	291	349	338
Biologics standards	295	275	333	293	333	296
National Cancer Institute	1,336	1,280	1,421	1,371	1,461	1,440
Allocation to Veterans' Administration	76	90	82	95	82	95
National Heart Institute	690	629	695	687	704	696
National Institute of Dental Research	301	290	324	305	331	320
National Institute of Arthritis and Metabolic Diseases	710	616	683	670	701	711
National Institute of Neurological Diseases and Blindness	725	693	795	795	818	813
National Institute of Allergy and Infectious Diseases	733	699	751	712	764	720
National Institute of General Medical Sciences	181	161	209	199	221	215
National Institute of Child Health and Human Development	371	311	430	377	493	419
Regional medical programs	50	13	135	128	149	142
Environmental health sciences	52	29	56	52	176	165
National Institutes of Health management fund	4,454	4,371	4,607	4,534	4,719	4,790
Service and supply fund	494	432	549	539	605	590
Advances and reimbursements	17	18	35	62	39	65
Total, National Institutes of Health	10,793	10,122	11,435	11,110	11,945	11,815
National Institute of Mental Health:						
Mental health research and services	2,285	2,228	2,494	2,458	2,744	2,666
Allocation to St. Elizabeths Hospital	14	14	14	14	14	14
Operation of commissaries, narcotic hospitals	12	11	12	10	12	10
Working capital fund, narcotic hospitals	48	49	47	46	47	45
Total, National Institute of Mental Health	2,359	2,302	2,567	2,528	2,817	2,735

All other Public Health Service:						
National health statistics	397	345	444	428	507	488
National Library of Medicine	356	302	397	355	447	397
Comprehensive health planning and services	104	94	107	97	244	228
Office of the Surgeon General, salaries and expenses	607	521	665	585	775	677
Service and supply fund	119	102	118	115	130	128
Advances and reimbursements	86	25	147	115	154	131
Total, other Public Health Service	1,669	1,389	1,878	1,695	2,257	2,049
Total	35,650	32,773	38,733	36,987	41,601	40,156
Allocations and allotments (net)	733	645	370	286	370	279
Total, Public Health Service	36,383	33,418	39,103	37,273	41,971	40,435
St. Elizabeths Hospital:						
Salaries and expenses	3,852	3,725	4,102	3,842	4,102	4,063
Advances and reimbursements	0	16	0	17	0	14
Total, St. Elizabeths Hospital	3,852	3,741	4,102	3,859	4,102	4,077
Social Security Administration:						
Salaries and expenses	44,014	42,101	47,592	45,899	49,010	47,295
Operating fund, Bureau of Federal Credit Unions	470	428	491	468	512	498
Advances and reimbursements	151	128	159	139	159	144
Total, President's budget	44,635	42,657	48,242	46,506	49,681	47,937
Allocations and allotments	6	5				
Total, Social Security Administration	44,641	42,662	48,242	46,506	49,681	47,937
Welfare Administration:						
Bureau of Family Services, salaries and expenses	630	485	660	564	709	648
Children's Bureau, salaries and expenses	421	359	436	380	467	425
Juvenile Delinquency and Youth Offenses		4		4		
Office of the Commissioner, salaries and expenses	96	76	103	91	126	112
Assistance to refugees in the United States	130	124	130	165	130	165
Advances and reimbursements	5	2	23	21	23	22
Total, President's budget	1,282	1,050	1,352	1,225	1,455	1,372
Allocations and allotments (net)	108	86	85	86	108	99
Total, Welfare Administration	1,390	1,136	1,437	1,311	1,563	1,471
Administration on Aging:						
Coordination and development of programs for the aging	89	54	87	81	105	94
Advances and reimbursements	10	7	15	10	15	10
Subtotal	99	61	102	91	120	104
Allocations and allotments (net)			2	2	2	2
Total, Administration on Aging	99	61	104	93	122	106
Freedmen's Hospital: Salaries and expenses	860	978	877	1,051	(1)	

Staffing Detail, Fiscal Years 1966, 1967, and 1968—Continued

	1966		1967		1968	
	Positions	Man-years	Positions	Man-years	Positions	Man-years
Office of the Secretary:						
Salaries and expenses, Office of the Secretary	153	116	471	441	647	603
Salaries and expenses, Office of Field Coordination	383	342	404	358	493	416
Salaries and expenses, Office of the Comptroller	434	366	458	419	595	522
Salaries and expenses, Office of Administration	213	185	215	186	244	203
Surplus property utilization	105	98	105	100	105	100
Salaries and expenses, Office of the General Counsel	277	224	293	271	303	288
Higher education for international understanding			49	48	142	118
Educational television facilities	23	20	23	23	23	23
Emergency health and welfare activities	207	208	193	184	218	193
Advances and reimbursements	65	49	44	44	44	37
Working capital fund	483	404	603	571	628	603
Total, President's budget	2,343	2,012	2,858	2,645	3,442	3,106
Allocations and allotments (net)	−183	−182	−356	−330	−379	−339
Total, Office of the Secretary	2,160	1,830	2,502	2,315	3,063	2,767
Total, Department of Health, Education, and Welfare	97,301	90,457	105,068	100,312	109,759	105,418

[1] With the transfer of Freedmen's Hospital to Howard University the positions assigned the hospital become non-Federal.

Fiscal Year 1967 Obligations and Employment as of Dec. 31, 1966

FOOD AND DRUG ADMINISTRATION

Appropriation account	Available for obligation	Available for obligation less reserve	Obligated as of Dec. 31, 1966	Unobligated balance as of Dec. 31, 1966	Personnel employed as of Dec. 31, 1966	Average number of positions budgeted for 1967
Salaries and expenses	$59,551,000	$59,551,000	$28,398,588	$31,252,412	4,526	4,606
Buildings and facilities	6,108,400	6,108,400	225,984	5,882,416	0	0

OFFICE OF EDUCATION

Expansion and improvement of vocational education	$284,418,820	$276,218,643	$47,438,967	$228,779,676		
Elementary and secondary educational activities	1,371,281,893	1,371,281,893	1,107,577,706	263,704,187		
Higher educational activities	423,400,000	420,200,000	18,621,801	401,578,199		
National Teachers Corps	7,500,000	7,500,000	4,076,194	3,423,806		
Student loan insurance fund	3,750,000	3,750,000		3,750,000		
Higher education facilities construction	533,295,533	524,272,533	96,909,122	427,363,411		
Higher education loan fund	200,000,000	100,000,000		100,000,000		
Further endowment of colleges of agriculture and the mechanic arts	11,950,000	11,950,000	11,950,000			
Grants for libraries	76,000,000	76,000,000	21,815,708	54,184,292		
Payments to school districts	416,200,000	407,200,000	63,681,283	343,518,717		
Assistance for school construction	54,563,000	54,563,000	13,115,356	41,447,644		
Defense educational activities	446,357,000	446,357,000	332,135,287	114,221,713		
Educational improvement for the handicapped	32,600,000	32,600,000	1,783,043	30,816,957		
Research and training	88,688,485	56,288,485	25,145,086	31,143,399		
Educational research (special foreign currency program)	1,938,395	1,938,395	80,454	1,857,941		
Foreign language training and area studies	3,000,000	3,000,000		3,000,000		
Salaries and expenses	34,759,000	34,759,000	20,417,280	14,341,720	2,092	2,152
Civil rights educational activities	8,000,000	8,000,000	3,740,281	4,259,719	63	84
Arts and humanities educational activities	1,000,000	1,000,000	425,482	574,518		
Colleges for agriculture and the mechanic arts (permanent)	2,550,000	2,550,000	2,550,000			
Promotion of Vocational Education, Act of Feb. 23, 1917 (permanent)	7,161,455	7,161,455	3,580,758	3,580,697		
Total	4,008,413,581	3,846,590,404	1,775,043,808	2,071,546,596	2,155	2,236

Fiscal Year 1967 Obligations and Employment as of Dec. 31, 1966—Continued

VOCATIONAL REHABILITATION ADMINISTRATION

Appropriation account	Available for obligation	Available for obligation less reserve	Obligated as of Dec. 31, 1966	Unobligated balance as of Dec. 31, 1966	Personnel employed as of Dec. 31, 1966	Average number of positions budgeted for 1967
Grants for rehabilitation services and facilities	[1] $246,914,310	[1] $246,414,310	$124,620,599	$121,723,711		
Research and training	60,325,000	59,490,000	47,423,756	12,066,244	3	5
Research and training (special foreign currency program)	[2] 4,499,812	[2] 4,499,812	2,358,732	2,141,080		
Grants for correctional rehabilitation study	800,000	809,000		800,000		
Salaries and expenses	5,168,000	5,168,000	2,134,929	3,033,071	318	366
Total	317,707,122	316,372,122	176,538,016	139,764,106	321	371
PUBLIC HEALTH SERVICE						
Buildings and facilities: Other	$46,827,138	$20,649,727	$10,549,479	$36,277,659		
Injury control:						
Grants	2,227,000	2,227,000	1,257,717	969,283		
Other	3,441,364	3,389,364	1,257,135	2,184,229		
Total	5,668,364	5,616,364	2,514,852	3,153,512	165	190
Chronic diseases and health of the aged:						
Grants	67,819,343	67,819,343	34,287,655	33,531,688		
Other	24,425,000	24,319,000	6,688,991	17,736,009		
Total	92,244,343	92,138,343	40,976,646	51,267,697	924	966
Communicable disease activities:						
Grants	15,161,733	15,161,733	3,510,514	11,651,219		
Other	32,932,000	32,760,000	18,698,821	14,233,179		
Total	48,093,733	47,921,733	22,209,335	25,884,398	1,928	1,814
Community health practice and research:						
Grants	92,728,247	92,591,247	20,838,584	71,889,663		
Other	8,320,000	8,288,000	2,712,150	5,607,850		
Total	101,048,247	100,879,247	23,550,734	77,497,513	310	335
Control of tuberculosis:						
Grants	17,950,000	17,950,000	12,349,760	5,600,240		
Other	3,647,000	3,617,000	1,521,263	2,125,737		
Total	21,597,000	21,567,000	13,871,023	7,725,977	341	338

Control of veneral diseases:						
Grants	6, 229, 000	6, 229, 000	5, 168, 446	10, 060, 554		
Other	4, 364, 000	4, 329, 000	2, 139, 065	2, 224, 935		
Total	10, 593, 000	10, 558, 000	7, 307, 511	3, 285, 489	730	949
Dental services and resources:						
Grants	5, 206, 000	5, 151, 000	2, 015, 665	3, 190, 335		
Other	4, 487, 000	4, 453, 000	1, 866, 970	2, 620, 030		
Total	9, 693, 000	9, 604, 000	3, 882, 635	5, 810, 365	247	264
Medical care services:						
Grants	6, 700, 000	6, 700, 000	6, 000, 296	699, 704		
Other	3, 527, 000	3, 494, 000	2, 159, 940	1, 367, 060		
Total	10, 227, 000	10, 194, 000	8, 160, 236	2, 066, 764	257	306
Nursing services and resources:						
Grants	23, 272, 000	22, 129, 000	11, 085, 313	12, 186, 687		
Other	2, 246, 000	2, 235, 000	1, 068, 581	1, 177, 149		
Total	25, 518, 000	24, 364, 000	12, 154, 164	13, 363, 836	166	170
Hospital construction activities:						
Grants	337, 421, 217	334, 921, 217	9, 595, 212	327, 826, 005		
1966–67 grants	227, 829, 907	227, 829, 907	34, 799, 950	193, 029, 957		
1966–68 grants	584, 092	584, 092	0	584, 092		
1965–67 grants	487, 969	487, 969	0	487, 969		
1967–69	817, 533	817, 533	0	817, 533		
Other	4, 427, 000	4, 425, 000	2, 205, 373	2, 221, 627		
Total	571, 567, 718	569, 065, 718	46, 600, 535	524, 967, 183	317	310
Construction of health educational facilities:						
Grants	190, 581, 040	190, 581, 040	27, 134, 597	163, 446, 443		
Other	727, 000	722, 000	289, 545	437, 455		
Total	191, 308, 040	191, 303, 040	27, 424, 142	163, 883, 898	73	46
Environmental health sciences:						
Grants	14, 051, 000	13, 981, 000	1, 964, 585	12, 086, 415		
Other	10, 247, 000	10, 093, 000	2, 201, 775	8, 045, 225		
Total	24, 298, 000	24, 074, 000	4. 166, 360	20, 131, 640	209	239
Air pollution:						
Grants	18, 426, 000	17, 686, 000	7, 518, 754	10, 907, 246		
Other	17, 135, 000	16, 879, 000	7, 667, 932	9, 467, 068		
Total	35, 561, 000	34, 565, 000	15, 186, 686	20, 374, 314	672	678

Fiscal Year 1967 Obligations and Employment as of Dec. 31, 1966—Continued

Appropriation account	Available for obligation	Available for obligation less reserve	Obligated as of Dec. 31, 1966	Unobligated balance as of Dec. 31, 1966	Personnel employed as of Dec. 31, 1966	Average number of positions budgeted for 1967
Environmental engineering and sanitation:						
Grants	$12,595,000	$12,288,000	$3,667,924	$8,927,076		
Other	9,368,000	9,240,000	3,227,345	6,140,655		
Total	21,963,000	21,528,000	6,895,269	15,067,731	499	520
Occupational health:						
Grants	2,988,000	2,988,000	1,243,339	1,744,661		
Other	3,604,000	3,571,000	1,386,220	2,217,780		
Total	6,592,000	6,559,000	2,629,559	3,962,441	196	223
Radiological health:						
Grants	7,377,000	7,332,000	3,394,110	3,982,890		
Other	13,518,000	13,391,000	6,532,561	6,985,439		
Total	20,895,000	20,723,000	9,926,671	10,968,329	828	776
Hospitals and medical care:						
Grants	1,200,000	1,200,000	600,000	600,000		
Other	72,927,000	72,927,000	36,723,001	36,203,999		
Total	74,127,000	74,127,000	37,323,001	36,803,999	7,012	6,943
Foreign quarantine: Other	8,030,000	8,030,000	4,281,001	3,748,999	655	660
General research and services:						
Grants	56,658,000	56,575,000	35,500,524	21,157,476		
Other	11,876,000	11,691,000	3,146,214	8,729,786		
Total	68,534,000	68,266,000	38,646,738	29,887,262	281	312
General medical sciences:						
Grants	138,314,000	138,307,000	49,659,508	88,654,492		
Other	6,799,000	6,781,000	2,457,881	4,341,119		
Total	145,113,000	145,088,000	52,117,389	92,995,611	202	199
Biologics standards: Other	7,904,000	7,796,000	2,529,947	5,374,053	283	290

National Institute of Child Health and Human Development:						
Grants	55,710,000	54,012,000	19,954,027	35,755,973		
Other	9,212,000	9,018,000	2,677,312	6,534,688		
Total	64,922,000	63,030,000	22,631,339	42,290,661	354	390
National Cancer Institute:						
Grants	92,788,000	92,788,000	33,644,478	59,143,522		
Other	82,868,000	82,555,000	29,614,102	53,253,898		
Total	175,656,000	175,343,000	63,258,580	112,397,420	1,371	1,421
National Institute of Mental Health:						
Grants	231,379,000	231,379,000	44,725,017	186,653,983		
Other	32,740,000	32,584,000	13,263,062	19,476,938		
Total	264,119,000	263,963,000	57,988,079	206,130,921	1,345	1,369
Construction of community mental health centers: Grants	93,091,941	93,091,941	2,331,193	90,760,748		
National Heart Institute:						
Grants	130,496,000	130,496,000	54,090,509	76,405,491		
Other	34,274,000	34,131,000	9,451,585	24,822,015		
Total	164,770,000	164,627,000	63,542,494	101,227,506	654	680
National Institute of Dental Research:						
Grants	22,215,000	22,215,000	7,471,711	14,743,289		
Other	6,093,000	6,050,000	2,693,815	3,399,185		
Total	28,308,000	28,265,000	10,165,526	18,142,474	301	313
National Institute of Arthritis and Metabolic Diseases:						
Grants	113,621,000	112,215,000	50,724,372	62,896,628		
Other	22,066,000	21,920,000	8,613,410	13,452,590		
Total	135,687,000	134,135,000	59,337,782	76,349,218	632	653
National Institute of Allergy and Infectious Diseases:						
Grants	64,809,000	64,809,000	27,085,534	37,723,466		
Other	25,861,000	25,697,000	9,089,476	16,771,524		
Total	90,670,000	90,506,000	36,175,010	54,494,990	703	715
National Institute of Neurological Diseases and Blindness:						
Grants	96,130,000	93,804,000	36,622,146	59,507,854		
Other	20,166,000	20,010,000	9,166,168	10,999,832		
Total	116,296,000	113,814,000	45,788,314	70,507,686	752	809
Grants for construction of health research facilities	56,027,350	41,027,350	11,975,039	44,052,311		

Fiscal Year 1967 Obligations and Employment as of Dec. 31, 1966—Continued

Appropriation account	Available for obligation	Available for obligation less reserve	Obligated as of Dec. 31, 1966	Unobligated balance as of Dec. 31, 1966	Personnel employed as of Dec. 31, 1966	Average number of positions budgeted for 1967
Regional medical programs:						
Grants	$64,945,581	$43,933,581	$9,951,846	$54,993,735		
Other	1,992,000	1,992,000	569,782	1,422,218		
Total	66,937,581	45,925,581	10,521,628	56,415,953	94	119
Construction of mental health-neurology research facility: Other	3,333,372	3,220,372	2,711,408	621,964		
National health statistics: Other	9,312,000	9,280,000	3,812,737	5,499,263	396	417
National Library of Medicine:						
Grants	15,488,828	7,988,828	143,833	15,344,995		
Other	7,737,000	7,672,000	2,587,006	5,149,994		
Total	23,225,828	15,660,828	2,730,839	20,494,989	343	353
Office of the Surgeon General, salaries and expenses: Other	7,798,000	7,765,000	3,269,546	4,528,454	645	614
Scientific activities overseas: Other	10,076,252	10,076,252	3,519,532	6,556,720		
Retired pay of commissioned officers: Other	10,743,000	10,743,000	3,323,236	7,419,764		
National Institutes of Health management fund: Other	50,601,000	50,601,000	24,135,047	26,465,953	4,577	4,551
Bureau of State Services management fund: Other	5,514,000	5,514,000	2,712,962	2,801,038	458	434
Total grants and loans	2,283,325,781	2,229,296,781	570,312,158	1,713,013,623		
Total other	641,165,126	611,908,715	252,522,046	388,643,080		
Grand total	2,924,490,907	2,841,205,496	822,834,204	2,101,656,703	28,920	29,366
ST. ELIZABETHS HOSPITAL						
Salaries and expenses	[1] $31,558,000	$31,558,000	$16,214,258	$15,343,742	3,736	3,842
Buildings and facilities	12,727,417	4,072,406	151,055	12,576,362		
Total, St. Elizabeths Hospital	44,285,417	35,630,406	16,365,313	27,920,104	3,736	3,842

SOCIAL SECURITY ADMINISTRATION						
Limitation on salaries and expenses (trust fund)[4]	[5] ($586,483,000)	[5 6] ($568,600,000)	[5 6] ($281,326,212)	($287,273,788)	46,085	45,899
Limitation on construction (trust fund)	(61,971,005)	(22,671,317)	(1,151,758)	(21,519,559)		
Payments to trust funds for health insurance for the aged	[7] 932,947,000	[7] 832,947,000	[7] 321,410,810	[7] 511,536,190		
Payments to trust funds for military service credits	105,000,000	105,000,000	105,000,000			
Total, Social Security Administration, (general funds only)	[7] 1,037,947,000	[7] 937,947,000	[7] 426,410,810	511,536,190		
WELFARE ADMINISTRATION						
Grants to States for public assistance [8]	$3,700,000,000	$3,700,000,000	$2,948,373,171	$751,626,829		
Assistance for repatriated U.S. nationals	460,000	420,000	177,242	242,758		
Bureau of Family Services, salaries and expenses	7,890,000	7,490,000	3,529,563	3,960,437	534	564
Grants for maternal and child welfare	228,900,000	225,900,000	181,143,918	44,756,082		
Children's Bureau, salaries and expenses	5,331,000	5,134,500	2,389,620	2,744,880	348	348
Juvenile delinquency and youth offenses	8,207,000	8,173,000	1,834,852	6,338,148	37	36
Cooperative research or demonstration projects	3,150,000	3,102,000	537,434	2,564,566		
Research and training (special foreign currency program)	1,679,552	1,679,552	547,507	1,132,045		
Office of the Commissioner, salaries and expenses	1,522,000	1,486,300	622,645	863,655	82	91
Total, Welfare Administration	3,957,139,552	3,953,385,352	3,139,155,952	814,229,400	1,001	1,039
ADMINISTRATION ON AGING						
Coordination and development of programs for the aging	$10,275,000	$9,620,000	$6,035,000	$3,607,000	80	81
AMERICAN PRINTING HOUSE FOR THE BLIND						
Education of the blind	$1,027,500		$1,027,500			
NATIONAL TECHNICAL INSTITUTE FOR THE DEAF						
National Technical Institute for the Deaf	$843,000	$843,000	$49,815	$793,185	2	3

See footnotes at end of table.

Fiscal Year 1967 Obligations and Employment as of Dec. 31, 1966—Continued

GALLAUDET COLLEGE

Appropriation account	Available for obligation	Available for obligation less reserve	Obligated as of Dec. 31, 1966	Unobligated balance as of Dec. 31, 1966	Personnel employed as of Dec. 31, 1966	Average number of positions budgeted for 1967
Salaries and expenses	$2,802,000	$2,802,000	$1,252,121	$1,549,879	305	312
Construction	729,638	553,119	72,616	480,503		

HOWARD UNIVERSITY

Salaries and expenses	$14,410,000	$14,410,000	$6,242,128	$8,167,872	2,329	2,484
Construction	14,185,781	4,437,903	1,123,046	3,314,857		

FREEDMEN'S HOSPITAL

Salaries and expenses	$9,474,000	$9,474,000	$4,312,593	$5,161,407	1,057	1,051

OFFICE OF THE SECRETARY

Salaries and expenses, office of the Secretary	$6,362,000	$6,362,000	$3,006,094	$3,355,906	362	441
Salaries and expenses, office of field coordination	3,454,000	3,454,000	1,727,652	1,726,348	340	358
Salaries and expenses, office of the comptroller	5,932,000	5,932,000	3,034,089	2,897,911	417	419
Salaries and expenses, office of administration	2,471,000	2,471,000	1,231,789	1,239,211	146	186
Surplus property utilization	1,093,000	1,093,000	555,196	537,804	96	100
Salaries and expenses, office of the general counsel	3,130,000	3,130,000	1,364,005	1,765,995	242	271
Higher education for international understanding	16,175,000	16,175,000	481,000	15,694,000	48	55
Educational television facilities	9,148,000	9,148,000	1,547,077	7,600,923	19	20
Total	47,765,000	47,765,000	12,946,902	34,818,098	1,670	1,850

[1] Excludes $15,000,000 proposed supplemental. Includes $2,854,310 unobligated balance brought forward.
[2] Includes $1,499,812 unobligated balance brought forward.
[3] Includes estimated reimbursements of $22,693,000 and excludes proposed supplemental of $1,047,000 ($995,000 appropriation and $52,000 in reimbursements).
[4] All figures exclude reimbursables.
[5] Excludes anticipated supplementals totaling $13,976,000.
[6] Excludes $17,883,000 balance of contingency reserve.
[7] Excludes proposed supplemental of $91,103,000.
[8] Appropriation apportioned on a deficiency basis; President's budget includes a supplemental proposed for later transmission which is excluded from the figures given above.

Funds Transferred to Committees, Commissions Councils, Etc.

Activity and agency	1966 actual [1]	1967 estimate	1968 estimate
Area coordinator program, Office of Federal Contract Compliance:			
Office of Education	$11,300	$11,300	----
Public Health Service	10,000	10,000	(2)
Total	21,300	21,300	----
Civil Service Commission, Interagency Board of Examiners:			
Food and Drug Administration	1,400	40,700	$63,400
Office of Education	700	28,300	43,300
Vocational Rehabilitation Administration	----	3,100	5,100
Public Health Service	10,400	158,400	246,200
St. Elizabeths Hospital	----	10,300	16,300
Social Security Administration	12,700	257,100	399,700
Welfare Administration	300	8,100	11,600
Administration on Aging	----	300	300
Office of the Secretary	500	15,600	25,900
Total	26,000	521,900	811,800
Civil Service Commission, summer employment program:			
Food and Drug Administration	550	----	----
Office of Education	650	----	----
Public Health Service	5,450	----	----
Social Security Administration	3,800	----	----
Welfare Administration	350	----	----
Office of the Secretary	100	----	----
Total	10,900	----	----
Committee on Government Patent Policy, Federal Council of Science and Technology; Public Health Service	----	20,000	----
Conference on Alcoholism; Office of Education	7,500	----	----
Federal Inquiry Center, General Services Administration:			
Office of Education	----	1,500	----
Public Health Service	----	2,000	(2)
Welfare Administration	----	500	----
Total	----	4,000	----
Federal science and engineering exhibit, Civil Service Commission:			
Food and Drug Administration	3,000	3,500	3,500
Public Health Service	3,000	3,500	3,500
Total	6,000	7,000	7,000
Interdepartmental Committee on the Status of Women:			
Office of Education	1,150	----	----
Social Security Administration	1,300	----	----
Welfare Administration	1,300	(2)	----
Total	3,750	----	----
National Advisory Commission on Health Manpower:			
Food and Drug Administration	----	9,100	----
Office of Education	----	9,100	----
Vocational Rehabilitation Administration	----	6,000	----
Public Health Service	----	225,000	----
Social Security Administration	----	35,800	----
Welfare Administration	----	15,000	----
Total	----	300,000	----
National Advisory Committee on Rural Poverty:			
Office of Education	----	15,000	----
Public Health Service	----	20,000	(2)
Welfare Administration	----	15,000	----
Total	----	50,000	----
National Conference on Spanish Speaking Problems:			
Office of Education	----	1,500	----
Public Health Service	----	12,000	----
Welfare Administration	----	1,500	----
Total	----	15,000	----

See footnotes at end of table.

Funds Transferred to Committees, Commissions Councils, Etc.—Continued

Activity and agency	1965 actual	1966 estimate	1967 estimate
National Council on Marine Resources and Engineering Development (special study): Public Health Service			$5,000
National Crime Commission (President's Committee on Law Enforcement and Administration of Justice): Welfare Administration		$117,521	
President's Commission on White House Fellowships: Office of Education	$35,000	35,000	
President's Committee on Consumer Interests:			
Food and Drug Administration	35,000		
Public Health Service	35,000	(3)	
Total	70,000		
President's Committee on Equal Employment Opportunity:			
Office of Education	3,240		
Public Health Service	3,860		
Federal Water Pollution Control Administration	1,000		
Total	8,100		
President's Committee on Juvenile Delinquency and Youth Crime:			
Office of Education	1,085		
Public Health Service	10,000	(3)	
Welfare Administration	74,167		
Total	85,252		
President's Committee on Mental Retardation:			
Public Health Service	96,000	92,000	
Social Security Administration	65,000	41,000	(4)
Welfare Administration	37,000	25,000	
Total	238,000	158,000	
President's Committee on Recreation and Natural Beauty:			
Food and Drug Administration		3,000	
Office of Education		2,000	(3)
Public Health Service		15,000	
Total		20,000	
President's Council on Equal Opportunity:			
Office of Education	16,000		
Public Health Service	24,00		
Total	40,000		
U.S. Civil Service Board of Examiners at Bureau of Standards: Food and Drug Administration	5,000	5,000	5,000
White House Conference on Civil Rights:			
Food and Drug Administration	3,000		
Office of Education	22,000		
Vocational Rehabilitation Administration	1,500		
Public Health Service	19,000		
Social Security Administration	13,000		
Welfare Administration	1,000		
Administration on Aging	500		
Office of the Secretary	2,500		
Federal Water Pollution Control Administration	500		
Total	63,000		
White House Conference on Health: Public Health Service	190,000		

[1] The report includes items funded by the Federal Water Pollution Control Administration since at the time funds were transferred, it was a part of the Department of Health, Education, and Welfare.
[2] No advice has been received by the Department on 1968 requirements.
[3] Beginning in 1967 these items are funded through direct appropriations.
[4] Beginning in 1968 funds for the President's Committee on Mental Retardation are requested under "Mental health research and services, Public Health Service."

Appropriations for Which Legislation Authorizes Funds To Remain Available Beyond the Budget Year

[Excludes direct construction]

Agency and account	Program	Length of availability
Office of Education:		
School assistance in federally affected areas.	Grants for school construction	Until expended.
Higher educational activities.	Program assistance:	
	Undergraduate instructional equipment and other resources.	2 years.
	Construction:	
	Public community colleges and technical institutes.	Do.
	Other undergraduate facilities	Do.
	Graduate facilities	Until expended.
	Loans	Do.
	Student aid:	
	Educational opportunity grants:	
	Grants to institutions	2 years.
	Insured loans:	
	Interest payments	Until expended.
	Work-study programs	2 years.
Expansion and improvement of vocational education.	Appalachian regional development student aid:	Until expended.
	Insured loans:	
	Interest payments	Do.
Libraries and community services.	Construction of public libraries	2 years.
Research and training	Educational laboratories and research and development centers:	
	Construction	Until expended.
Educational research and training (special foreign currency program).	Research in foreign education and training, research, and study grants.	Do.
Student loan insurance fund	Higher educational student loans	Until expended.
Higher education loan fund	Operating costs:	
	Participation sales insufficiencies	Do.
	Other expenses	Do.
	Capital outlay:	
	Higher education construction loans.	Do.
Vocational rehabilitation Administration:		
Research and training (special foreign currency program).	Foreign currency program	Do.
		Authority contained in annual appropriation act.
Grants for rehabilitation services and facilities.	Expansion grants	Funds to remain available through fiscal year 1971.
	Construction grants	Funds to remain available through fiscal year 1970.
Public Health Service:		
Health manpower education and utilization.	Nursing educational opportunity grants.	2 years.
Construction of health educational facilities.	Construction of teaching facilities for medical, dental, and other health personnel.	Until expended.
Communicable disease activities.	Community immunization grants	2 years.
Community Health Services	Grants for construction of university affiliated facilities.	Until expended.
		Authority contained in annual appropriation act.
	Grants for construction of community services facilities.	2 years.
Hospital construction activities.	Construction of hospital and medical facilities.	2 years. Guam, American Samoa, and the Virgin Islands, 3 years.
	Construction, equipment, and operation of demonstration health facilities.	Until expended.
Regional medical programs	Grants for regional medical programs	2 years.
Grants for construction of health research facilities.	Grants for construction of health research facilities.	Until expended.
Community Mental Health Resources Support.	Construction grants	2 years.
National Library of Medicine	Grants for construction of Medical library facilities.	Do.
	Grants for establisment of regional medical libraries.	Do.
Scientific activities overseas	Foreign currency program	Until expended.
		Authority contained in annual appropriation act.
Comprehensive health planning and services.	Grants to States for comprehensive State health planning.	2 years.

Appropriations for Which Legislation Authorizes Funds To Remain Available Beyond the Budget Year—Continued

[Excludes direct construction]

Agency and account	Program	Length of availability
Welfare Administration: Research and training (special foreign currency program).	Foreign currency program	Until expended. Authority contained in annual appropriation act.
Special Institutions: National Technical Institute for the Deaf.	Grants and administration	Do.
Model Secondary School for the Deaf.	Salaries and expenses and construction	Do.

Report on Mental Retardation Activities of the U.S. Department of Health, Education, and Welfare, 1967

(Prepared by the Secretary's Committee on Mental Retardation, Office of the Assistant Secretary for Individual and Family Services)

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PART ONE: INTRODUCTION

Coordination of Mental Retardation Programs

The mental retardation program of the Department of Health, Education, and Welfare is a direct response to the Report of the President's Panel on Mental Retardation, issued in October 1962. This Panel, appointed by the late President Kennedy in 1961, set forth 95 recommendations that constitute a national plan to combat mental retardation.

These recommendations are directed to all Federal, State and local agencies that have a part in the national mental retardation program. However, one-half of the recommendations designate the Department as one of the responsible agents. Thus, it is obvious that the Department plays a major role in the formulation of a comprehensive mental retardation program that is responsive to the needs expressed by the President's Panel on Mental Retardation.

The administration of mental retardation programs cannot be confined to any one health, education, or welfare area or a single disciplinary group. Since the total program includes a wide range of activities designed to attack problems of mental retardation simultaneously from many vantage points, the responsibility for the various programs has been assigned to those units within the Department that can bring the best professional and technical knowledge and administrative experience to this important new undertaking.

The Department offers a variety of professional and technical services related to the improvement and extension of mental retardation programs. The services provided are offered to States, interested groups, and individuals. Coordination of these services in the Department is the responsibility of Assistant Secretary Lisle C. Carter, Jr. The Secretary's Committee on Mental Retardation operates under the general direction of the Assistant Secretary. Some of the areas in which the staff of the Secretary's Committee on Mental Retardation is involved in coordination are: the support of interdisciplinary training programs in mental retardation university-affiliated facilities; cooperation with the Department of Defense in the program which provides assistance to mentally retarded dependents of active duty members of the uniformed services; serving as a focal point for contact with the newly established President's Committee on Mental Retardation.

Representatives serve on the Secretary's Committee from each unit of the Department that has a mental retardation program. Mental retardation activities are thus administered as a unified, whole program which has as its objective combating mental retardation with every resource at our disposal.

Among the duties of the Committee is the responsibility for keeping in close touch with groups outside of the Federal Government concerned with mental retardation programs. Examples of these groups are the Joseph P. Kennedy, Jr., Foundation, the National Association for Retarded Children, the Council on Exceptional Children, and the American Association on Mental Deficiency.

The staff of the Secretary's Committee on Mental Retardation serves as a focal point for information on all aspects of the Department's mental retardation program. It also acts as a center for the referral of requests for professional and technical consultation to the appropriate agencies. This activity is carried on in cooperation with the Department's Regional Offices and agency representatives in Washington. A list of the Regional Offices and Directors will be found in Appendix D.

Specifically, the Secretary's Committee is responsible for the following activities:

a. Serving the Secretary in an advisory capacity in the consideration of Department-wide policies, programs, procedures, activities, and related matters.

b. Serving in an advisory capacity for the Department as a whole with respect to inter-Departmental programs and activities, and related matters.

c. Functions as a means for coordination and evaluation of the implementation of the recommendations made by the President's Panel on Mental Retardation in its final report to the President.

The work of the Secretary's Committee on Mental Retardation is supplemented by means of the recently established Mental Retardation Steering Committee. This Committee, chaired by Assistant Secretary Carter, is composed of representatives of the Surgeon General, and the Commissioners of Education, Welfare and Vocational Rehabilitation. Its purpose is to provide policy review and determination in all matters relative to the Department's mental retardation program.

THE 1966 MENTAL RETARDATION LEGISLATION

Six new legislative proposals affecting the mentally retarded were enacted into law during the second session of the 89th Congress. Highlights of these laws are summarized in this Report.

1. P.L. 89–750, "Elementary and Secondary Education Act Amendments of 1966": Title VI of this law provides for the appropriation of $50 million for fiscal year 1967 and $150 million for fiscal year 1968 for the purpose of assisting the States in the initiation, expansion and improvement of programs and projects for the education of handicapped children. This includes mentally retarded children at the preschool, elementary and secondary school levels. A State's proportion of these funds is based on the number of children in the State aged 3 to 21 inclusive as it bears on the number of such children in all States. A special provision is made for Puerto Rico, Guam, American Samoa, the Virgin

Islands, the Trust Territories of the Pacific Islands. Any unexpended monies remain available for reallotment.

The States will submit to the Commissioner of Education a State plan which must provide satisfactory assurance that funds paid to the State under this Title will be expended either directly or through local education agencies solely to initiate, expand, or improve programs and projects (including preschool programs and projects) which are designed to meet the special educational and related needs of handicapped children throughout the State. The programs and projects must be of sufficient size and scope and quality as to give reasonable promise of substantial progress toward meeting these needs. They may include the acquisition of equipment and when necessary the construction of school facilities. The plan must also provide satisfactory assurance that to the extent consistent with the number and location of handicapped children in the State who are enrolled in private, elementary and secondary schools, provision will be made for participation of such children in programs assisted or carried out under this Title.

The new Title VI also requires the Commissioner of Education to establish in the Office of Education a National Advisory Committee on Handicapped Children which is to make recommendations to him concerning programs carried on for handicapped children by the Office of Education. Title VI also requires the Commissioner to establish and maintain within the Office of Education a Bureau for the Education and Training of Handicapped Children which shall be the principal agency in the Office of Education for administering and carrying out programs and projects relating to the education and training of the handicapped, including programs and projects for the training of teachers of the handicapped and for research in special education and training.

Additional information concerning this law may be secured from the Office of Education, Department of Health, Education, and Welfare, Washington, D.C., 20202.

2. P.L. 89–752, "Higher Education Act Amendments of 1966": Section 108 of this law adds to that Section of the Act which defines the term "academic facilities" a requirement that plans for such facilities comply with such standards as the Secretary of Health, Education, and Welfare may prescribe or approve to insure that the facilities constructed with Federal aid under this Act be accessible to and usable by handicapped persons to the extent appropriate in view of the uses to be made of the facilities.

This law provides for a cancellation provision for National Defense Education Act loans for those individuals who are training for work as teachers of handicapped children and for teaching in the Trust Territories of the Pacific Islands. The law provides up to 100% cancellation of a student loan at the rate of 15% per year of service by the debtor as a full-time teacher of handicapped children in a public or other nonprofit elementary or secondary school.

Additional information concerning this law may be secured from the Office of Education, Department of Health, Education, and Welfare, Washington, D.C. 20202.

3. P.L. 89–614, "Military Medical Benefit Amendments of 1966": This law consists entirely of amendments to the Dependents' Medical Care Act which deals primarily with health care benefits for the dependents of active duty members of the uniformed services (the Army, Navy, Marine Corps, Air Force, Coast Guard and the commissioned corps of the Public Health Service and the Environmental Science Services Administration.)

Included in the expanded benefits authorized by the new law (at an estimated first-year cost of $28.2 million) is a financial assistance program for active duty members who have a spouse or child who is moderately or severely mentally retarded or who has a serious physical handicap.

Under the new law, spouses or children with the type of conditions referred to above would be eligible under a new government-sponsored program for: diagnosis; inpatient, outpatient and home treatment; training, rehabilitation and special education; institutional care in public and private non-profit institutions and facilities and, when appropriate, transportation to and from such installations and facilities.

The law provides for a sliding scale of monthly deductibles payable by the active duty member, based upon his pay grade. Those in the lowest enlisted pay grade would be required to pay the first $25 each month of expenses incurred by their dependents. Four-star generals and admirals would similarly be required to pay the first $250. All other active duty members with participating depend-

ents would pay amounts in between these two amounts, as determined by the Secretary of Defense and the Secretary of Health, Education, and Welfare. The law provides that the government's share of the monthly costs shall not exceed $350 per month. Consequently, the active duty member would in some cases be required to pay an amount in addition to the deductible in order to meet the remaining difference between the government's share and the total monthly charge.

The "handicapped-retarded" portions of the new law stem from recognition of the fact that payment for care, training and special education of mentally retarded and physically handicapped dependents is frequently such a drain on the financial resources of the serviceman as to make it impossible for him to maintain an acceptable standard of living.

These portions of the new law were effective January 1, 1967. The Army, as Executive Agent for the Department of Defense and the Department of Health, Education, and Welfare, will operate the new program for all seven uniformed services. Additional information about this program may be secured from the Office for Dependents' Medical Care, Department of the Army, Denver, Colorado, 80240.

4. P.L. 89–749, "Comprehensive Health Planning and Public Health Services Amendments of 1966": Significant and extensive Federal legislation enacted in the last three years has enabled the States to assume sizable new functions and responsibilities in the field of health services. However, the development of coordination mechanisms has not kept pace with the growth and diversity of the Federally-aided health programs. The provisions of P.L. 89–749 will contribute significantly to meeting this need.

The new legislation authorizes a total of $24 million for a two-year program of grants for comprehensive health planning. These funds will be used to develop the intelligence and the administrative techniques necessary for such planning. The Act also authorizes $62.5 million for a one-year program of formula grants to States for comprehensive public health services; a redirected, flexible support to more clearly focus health program activities on bringing services to people. Health services for the mentally retarded are among those which may be supported with these funds. An additional sum of $62.5 million will be provided for a one-year program of health service developmental grants. These funds will be used to continue existing project grants, as well as to stimulate and initially support innovative health service programs, which include programs for the mentally retarded. The sum of $5 million is authorized for fiscal year 1968 for continuation of grants to schools of public health for comprehensive professional training and technical assistance in the field of public health. Temporary interchange of Federal and State personnel engaged in health-related work is also authorized in this Act.

The new law establishes a statutory framework for the revitalization and expansion of Federal-State-local cooperative efforts to make maximum use of national health resources, and strengthens State and local capacity and initiative modifying existing patterns of Federal financial assistance to States. This revision of the Federal health grant structure will make Federal grant funds available to States, and through them to local communities on a flexible basis, thus enabling these groups to focus on the needs of individuals and on families in their area. Communities will be better able to provide services for maintenance of good health as well as for rehabilitation following disease. Through the support of training and the interchange of Federal and State health personnel, competency and strength necessary for planning and administration of comprehensive health services can be improved.

Additional information concerning this new law may be secured from the Public Health Service, Department of Health, Education, and Welfare, Bethesda, Maryland, 20014.

5. P.L. 89–511, "Library Services and Construction Act": The handicapped, including the mentally retarded, will benefit from the provisions of this new Act which will add to the effectiveness and efficiency of the nation's library system.

Part A of Title IV authorizes a program to assist the States in providing library services in State institutions for inmates, patients, residents, and students who are physically or mentally handicapped.

States and territories have library agencies with responsibility to provide library services to persons in State-operated institutions. Most State agencies rate the present level of State institutional library service as "poor", and only 1 State reports it as "good". Personnel and books are the greatest needs. Estimated additional financial requirements of 13 States for State institutional

libraries to provide adequate service were reported to be $2.5 million. Federal funds now earmarked for library service to the handicapped should provide the needed impetus to the States to provide library service to citizens heretofore unable to obtain books and to improve existing services.

At present, 22 States do not have separate centers to provide books in braille and talking books. Some regional centers in States with large populations are desperately understaffed and overcrowded. They are unable to meet the increasing demands of blind readers and will not be able to provide any service to the other handicapped without additional personnel and space. Because of lack of funds the State regional libraries for the blind have had to depend upon the rather inefficient volunteer tape program to handle specialized needs such as that of text books for students. Additional funds will allow for a better coordination of this program and in certain instances, in the use of professional readers for textbook material.

Under the provisions of this new Act, State library agencies now have an opportunity to plan and possibly initiate programs that would provide books, other library materials and library services for students in residential schools for the mentally or physically handicapped. An Advisory Council of representative institutions will assist the State library agency to develop plans and programs under this Title. The authorization for appropriation is $5 million for fiscal year 1967, $7.5 million for fiscal year 1968, $10 million for fiscal year 1969, $12.5 million for fiscal year 1970, and $15 million for fiscal year 1971. Eligible State institutions will be informed by their State library agency when further information is available.

This program is administered by the Bureau of Adult and Vocational Education, Division of Library Services and Education Facilities, Office of Education, Department of Health, Education, and Welfare, Washington, D.C. 20202.

6. P.L. 89-601, "Fair Labor Standards Act Amendments of 1966"

The Fair Labor Standards Act, as amended in 1966, includes provisions to (1) extend the coverage of the minimum wage requirements to a number of groups including employees in hospitals, nursing homes, and most schools, both public and private, but exclusing Federal government hospitals, under certain conditions, and (2) make special provisions relating to students and handicapped workers.

For handicapped workers, the Secretary of Labor may issue special certificates allowing payment at not less than 50 percent of the minimum wage. The Secretary may grant special exemption from this requirement, upon certifications of the State vocational rehabilitation agency, for the employment of (a) "handicapped workers engaged in work which is incidental to training or evaluation programs," and (b) "multihandicapped individuals and other individuals whose earning capacity is so severely impaired that they are unable to engage in competitive employment."

The Secretary of Labor is also authorized to issue special certificates to allow employment of handicapped workers in work activity centers. The law defines these centers as "centers planned and designed exclusively to provide therapeutic activities for handicapped clients whose physical or mental impairment is so severe as to make their productive capacity inconsequential."

The Fair Labor Standards Act as amended in 1966 also directs the Secretary of Labor to conduct a complete study of wage payments to handicapped clients of sheltered workshops and of the feasibility of raising wage standards in such workshops. This report plus recommendations to Congress are due by July 1, 1967.

Additional information about this law may be secured from the Wage and Hour and Public Contracts Division, Department of Labor, Washington, D.C. 20210.

THE PRESIDENT'S COMMITTEE ON MENTAL RETARDATION

On May 11, President Johnson issued an Executive Order establishing the President's Committee on Mental Retardation. On this date the President also announced the appointment of twenty-one distinguished Americans to the Committee's public membership.

The Secretary of Health, Education, and Welfare, John W. Gardner, was designated Chairman. W. Willard Wirtz, Secretary of Labor, and R. Sargent Shriver, Director, Office of Economic Opportunity, serve in an ex-officio capacity.

The Committee's membership includes specialists in medicine, human development, special education and employment problems, members of foundations and other private organizations active in the mental retardation field.

Background

The President cited the following factors as background for the need to establish such a Committee at this time:

The Maternal and Child Health and Mental Retardation Planning Amendments of 1963 and the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 have established a firm statutory basis for combating mental retardation;

The mental retardation activities of Federal, State, and local government agencies and foundations and other private organizations are expanding rapidly and require careful review in order that maximum benefits may be achieved;

There is a continuing need to mobilize the support of the general public and of specialized professional groups for mental retardation activities; and

There is a need to re-evaluate existing programs to determine their adequacy and to consider proposals for new mental retardation activities.

Functions

The functions of the Committee are as follows:

(a) The Committee will provide such advice and assistance in the area of mental retardation as the President may from time to time request, including assistance with respect to:

(1) evaluation of the adequacy of the national effort to combat mental retardation;

(2) coordination of activities of Federal agencies in the mental retardation field;

(3) provision of adequate liaison between such Federal activities and related activities of State and local governments, foundations, and other private organizations; and

(4) development of such information, designed for dissemination to the general public, as will tend to reduce the incidence of mental retardation and ameliorate its effects.

(b) The Committee will mobilize support for mental retardation activities by meeting with, and providing information for, appropriate professional organizations and groups broadly representative of the general public.

(c) The Committee will make reports or recommendations to the President concerning mental retardation as he may require or the Committee may deem appropriate.

Relationship to Other Mental Retardation Groups

President's Panel on Mental Retardation: This group was appointed by President Kennedy in 1961. With the Report to the President in October 1962, the duties and functions of the Panel were completed. The President's Committee on Mental Retardation will evaluate the implementation of the Panel's Report and consider proposals for new mental retardation activities that have developed during the past few years.

Secretary's Committee on Mental Retardation: This Committee is composed of representatives of mental retardation programs within the Department of Health, Education, and Welfare; all members are employees of the Department. The Committee serves in an advisory capacity to the Secretary of Health, Education, and Welfare and coordinates the variety of mental retardation programs within the Department. This group will also provide assistance to the President's Committee on Mental Retardation in its efforts to carry out the functions of the new Committee.

Information

Additional information regarding the Committee may be secured from: Mr. David B. Ray, Jr., Executive Director, the President's Committee on Mental Retardation, Washington, D.C. 20201.

Membership

John W. Gardner, Chairman,
Secretary of Health, Education, and Welfare
W. Willard Wirtz
(Ex-Officio Member),
Secretary of Labor
R. Sargent Shriver
(Ex-Officio Member),
Director, Office of Economic Opportunity

Citizen Members

Robert H. Aldrich, M.D.
Joseph A. Beirne
G. Barry Bingham
Horace Busby
Robert E. Cooke, M.D.
John T. Dailey
Patrick J. Doyle, M.D.
Muriel B. Humphrey
(Mrs. Hubert H.)
George Jones
Mathilde Krim
(Mrs. Arthur)
Robert B. Kugel, M.D.
Leonard W. Mayo
Robert H. O'Brien
Lloyd E. Rader, Sr.
Theodore S. Repplier
Bernard Rosenberg
Eunice Kennedy Shriver
(Mrs. R. Sargent)
George Tarjan, M.D.
Thomas A. Tucker
Henry Viscardi, Jr.
Raymond W. Vowell

SUMMARY OF MENTAL RETARDATION ACTIVITIES

On November 7, 1966, President Johnson signed into law the fiscal year 1967 Appropriations Act for the Department of Health, Education, and Welfare (P.L. 89–787). During this fiscal year $358,146,546 of available funds is designed for mental retardation programs to be carried on by the operating agencies of the Department. $214,581,546 of this amount will be used for the support of a wide variety of activities including research, studies, demonstrations, professional preparation, services, construction, and planning. The remaining amount, $143,565,000, is to be used for income maintenance of persons who are mentally retarded.

The tables in Appendix A indicate the amounts appropriated to the Department in fiscal years 1966 and 1967 for the support of mental retardation programs. The mental retardation programs administered by each of the agencies of the Department are described in Part II of this publication. Following is a brief summary of these activities:

Preventive Services

Preventive services are defined as those services rendered as a part of programs designed to reduce the incidence of mental retardation. The major programs in this area are administered by the Children's Bureau, Welfare Administration. Maternity and Infant Care Projects support programs which provide necessary health care to prospective mothers in high risk populations. By December 1966, fifty-three such projects had been approved. Grants which support screening programs for phenylketonuria (PKU) and other metabolic diseases also are awarded by the Children's Bureau. As of November 1966, thirty-seven States had enacted laws related to PKU, most of them making screening for this disorder mandatory.

The Public Health Service carries on preventive services in relation to the health services provided beneficiaries of the Service.

Other Services

Other services are defined as those rendered to or for persons who are mentally retarded.

State health departments, crippled children's agencies and State welfare agencies use funds administered by the Children's Bureau and the Bureau of Family Services, Welfare Administration, for programs designed to: increase the health and welfare services available to the retarded, enlarge existing mental retardation clinics by adding clinic staff, increase the number of clinics, begin evaluations of children in institutions, extend screening programs, provide treatment services for physically handicapped retarded youngsters, increase inservice training opportunities, and provide homemaker and other care services for the mentally retarded.

The mentally retarded receive a variety of services through programs supported by the Vocational Rehabilitation Administration: medical diagnosis, physical restoration, counseling and testing during the rehabilitation process, assistance in job placement and follow-up to insure successful rehabilitation. P.L. 89–333, "Vocational Rehabilitation Act Amendments of 1965," is assisting in the rehabilitation of additional mentally retarded persons to productive life.

The Division of Mental Retardation, Public Health Service, gives high priority to the support of projects which demonstrate new techniques of providing serv-

ices to the mentally retarded, e.g., establishment of effective methods of referral; activities which facilitate care and management of the retarded; and improved methods of care, treatment and rehabilitation of the retarded. Major emphasis is given to projects which will result in the provision of the array of services needed for a continuum of care.

P.L. 89–750, "Elementary and Secondary Education Act Amendments of 1966," provides the opportunity for school districts to develop creative educational programs for the mentally retarded.

Professional Preparation

Training programs form an integral part of most of the mental retardation programs of the Department. These programs include support of professional preparation in the following areas: research training in the basic and clinical biological, medical and behavioral sciences, training of professional personnel for the provision of health, social and rehabilitative services for the mentally retarded; inservice training of workers in institutions for the mentally retarded; teachers and other education personnel related to the education of mentally retarded children.

P.L. 89–97, "Social Security Amendments of 1965," vastly increased the Department's program in the training of professional personnel who work with the mentally retarded. New authority included in this Act will make possible the training of a variety of additional personnel through grants to institutions of higher learning.

Research

The Public Health Service estimates that more than $30 million will be devoted in fiscal year 1966 to the support of research related to mental retardation.

The Office of Education administers a program of grants for research and demonstration projects in the area of education of mentally retarded and other handicapped children, and projects related to the application and adaption of communications media to educational problems of the mentally retarded.

The Vocational Rehabilitation Administration supports selected demonstration projects that seek to coordinate community resources for the mentally retarded. Particular attention is given to coordination between special education and vocational rehabilitation agencies. Three Rehabilitation Research and Training Centers for the mentally retarded, supported by the Vocational Rehabilitation Administration, provide for the diagnosis, evaluation, treatment and training, vocational counseling and placement of the mentally retarded.

Research grants administered by the Children's Bureau support projects directed toward the evaluation of programs and improving the development, management and effectiveness of maternal and child health and crippled children's services.

Construction

Title I of P.L. 88–164, "Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963," provides for the construction of three types of facilities for the mentally retarded. These construction programs are all administered by the Public Health Service.

Research Centers will assist in the development of new knowledge for preventing and combating mental retardation. Awards made to date provide for five such Centers.

University-affiliated facilities for the mentally retarded will provide for training of physicians and other professional personnel vitally needed to work with the mentally retarded. Ten applications have been approved under this program.

Over 100 projects for the construction of community facilities for the mentally retarded have been approved. The facilities constructed under this legislation will include a variety of services: diagnosis, treatment, education, training or care of the mentally retarded, including sheltered workshops.

State Coordination

P.L. 89–97 provides funds for the implementation of the State mental retardation comprehensive plans which were supported under grants available in P.L. 88–156, "Maternal and Child Health and Mental Retardation Planning Amendments of 1963." This program is administered by the Division of Mental Retardation, Public Health Service.

Citizen Members

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Other Services

Other services are defined as those rendered to or for persons who are mentally retarded.

State health departments, crippled children's agencies and State welfare agencies use funds administered by the Children's Bureau and the Bureau of Family Services, Welfare Administration, for programs designed to: increase the health and welfare services available to the retarded, enlarge existing mental retardation clinics by adding clinic staff, increase the number of clinics, begin evaluations of children in institutions, extend screening programs, provide treatment services for physically handicapped retarded youngsters, increase inservice training opportunities, and provide homemaker and other care services for the mentally retarded.

The mentally retarded receive a variety of services through programs supported by the Vocational Rehabilitation Administration: medical diagnosis, physical restoration, counseling and testing during the rehabilitation process, assistance in job placement and follow-up to insure successful rehabilitation. P.L. 89–333, "Vocational Rehabilitation Act Amendments of 1965," is assisting in the rehabilitation of additional mentally retarded persons to productive life.

The Division of Mental Retardation, Public Health Service, gives high priority to the support of projects which demonstrate new techniques of providing serv-

ices to the mentally retarded, e.g., establishment of effective methods of referral; activities which facilitate care and management of the retarded; and improved methods of care, treatment and rehabilitation of the retarded. Major emphasis is given to projects which will result in the provision of the array of services needed for a continuum of care.

P.L. 89–750, "Elementary and Secondary Education Act Amendments of 1966," provides the opportunity for school districts to develop creative educational programs for the mentally retarded.

Professional Preparation

Training programs form an integral part of most of the mental retardation programs of the Department. These programs include support of professional preparation in the following areas: research training in the basic and clinical biological, medical and behavioral sciences, training of professional personnel for the provision of health, social and rehabilitative services for the mentally retarded; inservice training of workers in institutions for the mentally retarded; teachers and other education personnel related to the education of mentally retarded children.

P.L. 89–97, "Social Security Amendments of 1965," vastly increased the Department's program in the training of professional personnel who work with the mentally retarded. New authority included in this Act will make possible the training of a variety of additional personnel through grants to institutions of higher learning.

Research

The Public Health Service estimates that more than $30 million will be devoted in fiscal year 1966 to the support of research related to mental retardation.

The Office of Education administers a program of grants for research and demonstration projects in the area of education of mentally retarded and other handicapped children, and projects related to the application and adaption of communications media to educational problems of the mentally retarded.

The Vocational Rehabilitation Administration supports selected demonstration projects that seek to coordinate community resources for the mentally retarded. Particular attention is given to coordination between special education and vocational rehabilitation agencies. Three Rehabilitation Research and Training Centers for the mentally retarded, supported by the Vocational Rehabilitation Administration, provide for the diagnosis, evaluation, treatment and training, vocational counseling and placement of the mentally retarded.

Research grants administered by the Children's Bureau support projects directed toward the evaluation of programs and improving the development, management and effectiveness of maternal and child health and crippled children's services.

Construction

Title I of P.L. 88–164, "Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963," provides for the construction of three types of facilities for the mentally retarded. These construction programs are all administered by the Public Health Service.

Research Centers will assist in the development of new knowledge for preventing and combating mental retardation. Awards made to date provide for five such Centers.

University-affiliated facilities for the mentally retarded will provide for training of physicians and other professional personnel vitally needed to work with the mentally retarded. Ten applications have been approved under this program.

Over 100 projects for the construction of community facilities for the mentally retarded have been approved. The facilities constructed under this legislation will include a variety of services: diagnosis, treatment, education, training or care of the mentally retarded, including sheltered workshops.

State Coordination

P.L. 89–97 provides funds for the implementation of the State mental retardation comprehensive plans which were supported under grants available in P.L. 88–156, "Maternal and Child Health and Mental Retardation Planning Amendments of 1963." This program is administered by the Division of Mental Retardation, Public Health Service.

Income Maintenance

The Bureau of Family Services, Welfare Administration, administers the five Federally-supported public assistance programs. These programs assist children who are deprived of parental support or care, the needy aged the medically indigent aged, the needy blind, and the permanently and totally disabled. Mental retardation itself is an eligibility factor only in the category of aid to the permanently and totally disabled.

The social security program, administered by the Social Security Administration, contributes to the maintenance of the mentally retarded through the payment of monthly benefits to eligible recipients.

PART TWO: MENTAL RETARDATION ACTIVITIES OF THE DEPARTMENT

Public Health Service

INTRODUCTION

The Public Health Service, as the principal health agency of the Federal Government, is responsible for the conduct or support of a broad spectrum of services, research, manpower development, facilities construction, and planning for the prevention, diagnosis, treatment, or amelioration of mental retardation as a health problem. In addition, mental retardation has significant ramifications for a host of activities of the Public Health Service which are focused on broader targets or are concerned with disease categories and health problems inextricably related to mental retardation. This report attempts to highlight the most relevant of these activities.

The Public Health Service program activities described on the following pages are arranged according to their nature (training; reasearch; construction; etc.) and also according to their purposes and most important potential contribution (fundamental research; prevention of organically-based mental retardation; treatment and other amelioration for mental retardates; etc.). While difficulties exist in differentiating the causes of individual cases of mental retardation according to whether they are organic or functional, a concerted effort has been made to classify relevant program activities focusing on "organic" or "functional" mental retardation where such a distinction helps us all understand where we are now and what health actions we need to take in the future to prevent or treat mental retardation.

The importance of these program activities is emphasized by the establishment of a new Division of Mental Retardation in the Bureau of Health Services, under the reorganization of the Public Health Service effective January 1, 1967. Responsibilities of this new Division will include the activities previously undertaken by the Mental Retardaton Branch of the Division of Chronic Diseases; the Hospital Improvement Program and Hospital Inservice Training as these programs relate to mental retardation; construction programs for community facilities and university-affiliated centers; provision of information and consultation on all phases of the care of the retardate; and the development of techniques of program evaluation in broad areas of concern for total life span of the retardate. For the convenience of this report, activities which will become the responsibility of this new Division, although carried out under its predecessor agencies and programs in 1966, will be ascribed to the Division of Mental Retardation. Similarly, the activities undertaken in 1966 by the Bureau of Medical Services are ascribed to the newly organized Bureau of Health Services.

Overall program coordination and direction of mental retardation activties within the Public Health Services is the responsibility of the Associate Surgeon General.

I. Preventive Services

A. *Prevention of organically-based mental retardation.*—The prevention of mental retardation caused by organic factors is best accomplished by continuous, comprehensive, and excellent medical care of pregnant women and their offspring in the prenatal and postnatal periods. The Public Health Service, through its efforts to provide exemplary medical care to its legal beneficiaries, is reducing the incidence of organically-based mental retardation as well as the wide variety of other diseases and conditions in mothers and infants which the state of the art in medicine now makes at least partially controllable.

In the two Public Health Service general hospitals which operate obstetrical services, comprehensive prenatal and neonatal care is given specifically to reduce the incidence of mental retardation. Phenylketonuria (PKU) tests are performed on all newborn infants, and infants with a depressed Apgar score or who are prematurely born are evaluated for PKU or other evidence of brain damage.

Both the Division of Hospital and Medical Facilities and the Division of Indian Health provide comprehensive medical care during prenatal, perinatal, and postnatal periods. In the Division of Hospital and Medical Facilities, patients are referred to other agencies for genetic counseling, specific genetic studies, etc.

The Division of Indian Health has increased the number and frequency of maternal clinics for Indian mothers during the prenatal period and has also expanded its measles immunization program for Indian and Alaska Native children, to help prevent the measles encephalitis which has a high residual of brain damage of which mental retardation can be one of several adverse consequences.

The Division of Indian Health continues to develop its PKU blood screening program concurrently with the development of laboratory facilities by States in which their facilities are located. Individual Indian Health Area Offices cooperate with State and local health departments and Regional Offices in planning mental retardation programs made possible through Grants-In-Aid Funds from the Children's Bureau. Also, the Division is working with the Children's Bureau to determine the best utilization of the professionally trained nurse-midwife in the prevention of mental retardation through improved care of expectant mothers and newborn infants.

B. *Prevention of functionally-based mental retardation.*—As a part of the ongoing comprehensive health program on one Indian reservation, a mental health project includes work with prevention, detection, and treatment planning for functional mental retardation. The Division of Indian Health is cooperatively working with Head Start Program throughout all of its seven areas.

II. Other Services

A. *Community Services.*—The Division of Mental Retardation gives a high priority to project proposals which will result in expanded or improved services for the retarded at the community level or on a regional basis. Grants are available for projects devoted to: (1) establishment of effective methods of referral, (2) coordination of existing agency programs and other activities which facilitate the care and management of the retarded, (3) programs of patient care services, and (4) demonstration of new techniques of providing services. In addition, major emphasis is given to proposed projects which will supplement the existing services of community agencies, thus resulting in the array of services needed for a continuum of care. An example of this type of project is the development of outpatient services by a residential institution to serve the community in collaboration with other health agencies.

For example, the Division of Mental Retardation is supporting a demonstration project to organize and initiate a county-wide system of Daytime Development Centers, where an extensive program of care, training, and/or education will be provided for the mentally retarded persons whose needs are not presently being met. The activities of the Centers will assist the retardates in becoming more self-sufficient, and will provide some relief during the daytime hours for the retardate's family. Family counseling will be part of the program.

Another example of a project now being supported to demonstrate new techniques of providing services is a diagnostic and evaluation clinic which meets one day per month for examination of 8 to 10 children and a second day each month for staff discussion. Continuity and follow-up is provided by one full-time social worker and one full-time clerical person. The cost for this type of diagnosis is approximately one-fifth of that of conventional diagnostic and evaluation clinics.

Another demonstration project applies laboratory-derived principles in modifying the personal, social, educational, and occupational behavior of moderately and severely retarded, institutionalized girls. The primary technique is systematic, controlled rewarding of desired behavior.

The Division is also supporting a project in which the narrative standards for residential facilities, as promulgated by AAMD in 1961, are being updated and converted to a rating device and used to establish a "base line" for the assessment of institutions. It is hoped that this activity will lead to a form of accreditation, with resultant improvement of services to the retarded.

B. *Hospital Improvement Project Grant Program.*—The Hospital Improvement Project Grant Program is designed to assist State mental hospitals and State institutions for the mentally retarded to develop demonstrations of improved methods of care, treatment, and rehabilitation of the mentally ill and the mentally retarded. The program is specifically focused on the use of current knowledge in demonstration of improved services and care, as opposed to research explorations and development of new knowledge.

Each State institution for the mentally retarded is eligible to apply for up to a maximum of $100,000 per year for a period of up to ten years. While an individual project grant application is required, an institution may apply for concurrent grants, or a series of consecutive grants, so that a programmatic approach to use of the program in improvement of services is both possible and encouraged. Projects should be planned in response to the high priority needs of the institution and should be directed toward the ultimate improvement of patient care throughout the entire institution.

An analysis of the current Hospital Improvement Projects shows that over 50 percent of the projects are focused on specialized services for residents who will require long-term care and treatment. A number of these projects involve retardates functioning at the severe and profound levels of retardation, some involve multiple handicapped residents, and a few are concerned with aged residents. Demonstration projects for these more retarded and dependent residents are emphasizing personal development in self-care training, socialization experiences, intensive medical diagnosis and treatment, and improved speech and oral communication.

A number of projects have focused on special program areas, such as programs for emotionally disturbed and/or socially maladjusted retardates, pre-vocational training for adolescents, and programs of treatment, training, and social habilitation for new admissions in the mild and moderate levels of retardation. Of special significance are the number of projects for emotionally disturbed and/or socially maladjusted residents. There is a constant increase in the numbers of maladjusted retardates being admitted to institutions and in need of special programs. Projects developed for these residents include the application of newer training methods based on learning theory and principles, the development of social competency, and attention to pre-vocational areas. Other projects provide a diversified range of improved services, such as placement preparation and field services, speech therapy, medical-physical diagnosis and treatment, recreation services, social-vocational habilitation, diagnostic study with improved records and program planning, use of the unit system, and various methods of alternatives to institutional placement, such as day and night care, all of which enhance the development of an institution-community continuum of services.

The Hospital Improvement Project Grant Program was initiated in 1964 as an extension of the Mental Health Project Grant Program. By the end of 1966, 89 of the State institutions for the mentally retarded had received awards. This means that over 65 percent of the eligible institutions are included in the program. All but three States had at least one grant for an institution for the retarded.

Although the program has been in operation less than three years, it is already clear that many of the severely and profoundly retarded residents are benefitting; some are able to participate in more advanced developmental programs of the institution, and others are returning to the family and community. There is evidence that this success is changing staff attitudes and "de-institutionalizing" staff attitudes and behavior. For many institutions a project is stimulating improved institution-community program coordination, and more effective use of resources, including those of the community, and nearby university and college personnel.

Major emphasis in this program during the next year will be placed on extension of coverage to those institutions that are not yet involved in the program and development of long-term collaborative efforts of the staff of the institutions receiving grants, their State agencies, and the Public Health Service to assess and share findings in relation to problems and methods of improvement of institutional care programs. Coordination of institution programs with community programs and State-wide comprehensive planning is also an important objective.

C. *The Division of Foreign Quarantine.*—This Division has been working with other Federal agencies and voluntary groups to make the best possible arrange-

ments for the reception and treatment of the mentally retarded coming to this country as immigrants.

The detection and diagnosis of mental retardation in aliens desiring to come to this country is a specific function of the Division of Foreign Quarantine. Since mental retardation is an excludable condition except for those eligible for waiver Public Health Service psychiatrists and psychologists review all cases of mental retardation discovered in visa applicants around the world.

For those mentally retarded aliens admitted to the United States, the Service is responsible for complete reports and review of arrangements for treatment in this country. A record is then kept covering the first five years of the individual's treatment in this country, which must be provided in institutions or special facilities approved by the Public Health Service. Semi-annual reports showing kind of treatment and progress made are required and kept on file at the Quarantine Station in New York.

D. *Community Mental Health Centers Program.*—While there are differences between mental illness and mental retardation, the two problems frequently occur in the same patient and require some of the same professional skills for diagnosis and treatment. In view of this overlap, the Community Mental Health Centers Program, initiated in 1963, has a definite role in providing services related to the mental health needs of the mentally retarded. The Centers also serve as a referral source to needed services that are not available in the Centers. Community Mental Health Centers will provide five "essential elements" of service: inpatient services; outpatient services; partial hospitalization; emergency services; consultation and education services.

E. *The Public Health Service's Hospitals.*—The Public Health Service's hospitals, through their social service units, refer any mentally retarded persons for whom they have medical care responsibilities to appropriate community resources for diagnostic studies, evaluation, rehabilitation, custodial care, etc.

III. Professional Preparation

A. *Research Training (National Institutes of Child Health and Human Development).*—A major objective of the National Institute of Child Health and Human Development is to stimulate the development of research manpower resources in mental retardation. The number of training grants, fellowships, and research career development awards have shown a near twofold increase in 1966 and over 1965. Still there is a critical need for more biomedical and behavioral research workers whose primary interests lie in areas related to mental retardation. This need will become acute when the mental retardation research centers become operational. It is estimated that 70 additional investigators will be needed in each center within two years after the completion of a Center. For the ten Centers scheduled to be operational by 1971 this translates to a need for over 700 new, trained researchers by 1973.

Thirteen training grants are currently being supported, providing training for 61 trainees. Forty of the trainees are at the predoctoral level and 21 receive post-doctoral training. The training programs are concentrated in the areas of pediatrics, psychology, biochemistry, metabolism, and genetics.

Post-doctoral and special fellowships have been awarded to thirteen young investigators who are developing skills to conduct research in areas such as cytogenetics, learning, physical performance potential, and biochemistry as these relate to mental subnormality.

The Research Career Program is designed to increase stable, full-time career opportunities for scientists of superior potential and capability. Six outstanding scientists have received Research Career Development Awards and are pursuing investigations on learning, inborn errors of metabolism, human differentiation, and biochemical abnormalities in mental retardation.

In addition to the above training efforts, which focus specifically on mental retardation, the National Institute of Child Health and Human Development currently supports fellowships, research career awards, and training grants in areas highly relevant to mental retardation. With the assistance of the Child Development and Mental Retardation Training Committee, programming of training grants was intensified in 1966 by contacting a large number of scientists in the field to encourage them to develop small research training programs.

B. *Training for Health Services to the Mentally Retarded (Division of Mental Retardation).*—The Division of Mental Retardation is concerned with increasing the number and competence of medical and allied health personnel to provide health services to the mentally retarded.

Twenty universities are receiving support for planning and developing comprehensive multidisciplinary training programs in mental retardation, which will provide training for a great many vitally needed professionals in the future. The Public Health Service is currently supporting health-related training programs within these centers in a wide range of disciplines.

Forty training projects in mental retardation are being supported, of which 20 are long-term, preservice, and 20 are short-term, mostly continuing education projects. Included are projects in medicine, psychology, social work, nursing, physical therapy, dentistry, and other related health disciplines, as well as supportive and other subprofessional personnel categories.

The program is also providing support for 50 projects, including 700 students, in the recruitment and career motivation areas. Student Work Experience and Training (SWEAT) projects provide students with employment during summer months, and other vacation periods, and an opportunity to work directly with mentally retarded children and adults.

Individual traineeship grants have been awarded to 54 post-resident, graduate, and post-R.N. students to pursue professional careers in mental retardation in the fields of medicine, psychology, social work, nursing, recreational therapy, speech therapy, and music therapy.

C. *Training for Research and Services (National Institute of Mental Health).*—Several of the programs of the National Institute of Mental Health are directly concerned with the training of personnel who will either provide service or conduct research in the area of mental retardation. In addition, almost all programs in psychiatry, psychology, social work, and psychiatric nursing provide experience relevant to mental retardation as an integral part of the training of personnel in these disciplines. In recent years, support for training in mental retardation has been broadened to include programs in the biological and social sciences, as well as pilot projects in a number of related areas. Significant expansion of training support related to retardation occurred in fiscal year 1964 with a new program of inservice training (see below) designed to upgrade the training of house parents and attendants in institutions for the mentally retarded.

The discipline of social work supports the largest number of projects in mental retardation. These projects typically provide field-work unit supervision and student field placements in institutions for the mentally retarded. In addition, support has been provided for additional faculty and for faculty enrichment to expand the scope of training of social workers for service to the retarded.

An illustrative training program in psychiatry provides psychiatric training in various aspects of mental retardation, including: participation in the outpatient clinic of a State school for the retarded; ward rounds; examinations of patients with specific problems; studies of the histories of patients in association with the social service department of the school; and the various types of laboratory studies. Another psychiatry project provides support for the addition of faculty to function primarily in the development and refinement of training for professional personnel in the field of mental retardation. Fellows and residents in psychiatry receive training in diagnostic and evaluative studies of all types of retarded children, as well as psychotherapeutic work with emotionally disturbed retarded children and their parents. The training provided is interdisciplinary, and includes the participation of psychiatrists, neurologists, pediatricians, psychologists, psychiatric socal workers, psychatric nurses, and educational therapists.

In the area of psychiatric nursing, support is provided for a program of training in mental retardation in connection with an ongoing program in child psychiatry at the same training institution. Another recent project supported nurses to develop a program in child psychiatric nursing, including problems of retardation.

Within the discipline of psychology, support is provided for both research and clinical training in mental retardation in relation to, or as a sub-specialty of, training in clinical, learning, child, or school psychology. One such program requires a year's internship at a suitable facility where research and clinical work are expected of each trainee. A project in clinical psychology stresses interdisciplinary training with psychiatrists, psychologists, social workers, teachers, and rehabilitation specialists working closely together. Another project in clinical psychology has provided experience in diagnostic evaluation, supervision of practicum students, and supervised individual therapy with children who demonstrated both mental retardation and emotional disturbances.

A pilot project in a mental retardation unit of a department of pediatrics provides postgraduate interdisciplinary training for persons from relevant professions and para-professions in the treatment of retardates in the community. Another pilot project provides interdisciplinary training for houseparents for residental child-treatment institutions. A third illustration in pilot endeavor, also interdisciplinary, provides a one-year internship for doctoral candidates in a variety of mental health fields in research training in the area of mental retardation.

A recent and significant addition to the National Institute of Mental Health efforts to help improve the quality of programs offered institutionalized mental retardates is the Inservice Training Program. The long-range objectives of the Inservice Training Program are twofold: (1) to increase on a continuing basis the effectiveness of all employees in hospitals for the mentally ill and training schools for the mentally retarded; (2) to translate rapidly increasing knowledge into more effective services to people by means of inservice training broadly defined to include: pre-service training, job-related training; inservice training, continuing education, special training and technical training needed to introduce new methods, and training to make better employees.

In recognition of the fact that personnel such as attendants, houseparents, psychiatric aides, and others in the personnel category comprise over 84 percent of those rendering direct care training to institutionalized retardates, the first major area of grant support was extended to these personnel. Grant support for inservice training has since been broadened to include all professional, subprofessional, and technical personnel who have direct responsibilities for resident care and training. This expansion of the inservice training program is in addition to, not in lieu of, the support for training cottage and ward life personnel.

Every State residential facility for the mentally retarded is eligible to participate in this program. The maximum grant to a single institution may not exceed $25,000 in any one year. These grants can be made for a period of up to seven years and are renewable.

The types of training supported by inservice training grants to institutions for the mentally retarded can be categorized under four headings: (a) refresher training, (b) continuation training, (c) supervisory training, and (d) instructor training. The latter aspect is aimed at providing a cadre of personnel to continue and extend the training programs.

Personnel categories involved as trainees in these programs are (listed in order of descending frequency): aides, attendants, charge aides, supervisors, registered nurses, practical nurses, and houseparents.

The content of the training programs must often include: (1) basic information about mental retardation, child growth and development, and nursing care skills; (2) patient-staff relations, human behavior, intra-staff relations, supervisory, and communications skills; and (3) psycho-pathology and adjunctive therapy skills.

This grant program was initiated in 1964. Grants have been made to 99, or over 70 percent, of the eligible institutions. Institutions in 45 States are participating in the program. Consultation is given to institutions that have received grants to assist them in making the most effective use of training opportunities. Technical information and professional consultation is being provided to the remaining State institutions for the mentally retarded to enable them to qualify for similar grants.

D. Training of Neurologists for Services and Research (National Institute of Neurological Diseases and Blindness)

While the training program of the National Institute of Neurological Diseases and Blindness is not specifically and exclusively directed towards mental retardation, it is directed toward the development of clinical neurologists and competent research scientists in the fields associated with the diseases of the nervous system. These disciplines provide the basic tools required for any serious attack on the problem of organically-based mental retardation. Particularly important are the Institute programs for the training of pediatric neurologists, who are very often required to make the initial diagnosis of mental retardation. Training programs in speech pathology and audiology are fundamental to therapy in the mentally retarded and receive strong support from the Institute.

E. Educational and Training Efforts by the Bureau of Health Services

Coping with mental retardation among its legal beneficiaries is only one of the many health responsibilities for which Bureau of Health Services personnel

must be prepared; nevertheless, several aspects of the Bureau's training program are clearly relevant and important to the attack on mental retardation.

Post-graduate training programs in Public Health Service Hospitals include rotating internships, and residencies in internal medicine and obstetrics which involve maternal and pediatric clinical training and the diagnosis and treatment of mental retardation as it arises in the patient population. Research training is conducted in metabolism and endocrinology, disciplines basic to some forms of mental retardation.

The Division of Indian Health continues to provide both inservice and out-of-service training in maternal and child health nursing to ensure continuity of service from hospital to home and community. An average of 12 nurses are trained each year. Many of the Division's Areas continue to develop and use coordinated teaching guides for hospital and public health nursing personnel, designed as aids in teaching good health practices to maternity patients and their families.

IV. Research and Development Activities

A. *Research Related to Organically-Based Mental Retardation.*—1. National Institute of Child Health and Human Development: Research into the biological bases of mental retardation is progressing along many lines. Studies include the epidemiology and etiology of disease factors, diagnosis, pathogenesis, prevention, and treatment of conditions related to mental retardation within the broad context of child and human development. The following are brief illustrative summaries of research supported by the National Institutes of Child Health and Human Development:

Advances in biochemical genetics in recent years have stimulated intensive studies in chromosomal abnormalities. Attempts are being made to correlate biochemical deviations with chromosomal anomalies and associated clinical manifestations. Mapping of gene locations on human chromosomes in mongolism and other disorders should add to our knowledge of how these aberrations occur and their possible prevention.

Numerous studies are in process on the role of inborn errors of metabolism in the etiology of mental retardation. The detection of disorders such as phenylketonuria, galactosemia, histidenemia, and others in the new-born is an essential first step in the treatment of these conditions. The investigation of questions related to initiation and duration of therapy, diet control, and the role of educational and social environmental factors in intellectual and physiological development is yielding important information regarding treatment regimens.

Respiratory distress syndrome, viral infections in the first trimester of pregnancy, and other infections disease processes are known agents in the causation of mental defect and congenital malformations. Rubella and infectious hepatitis in particular are suspected of causing chromosome aberrations. Grantees are studying the occurrence of infectious diseases in areas where a high incidence of abnormal births are reported and extending these investigations into stillbirth and spontaneous abortion populations. Studies utilizing dermatoglyphic techniques also offer promise for identifying damage in newborns occurring during the intrauterine period that is not associated with chromosomal errors. To stimulate more research activity in infectious diseases and to review current knowledge in this area, the Institute recently sponsored an international conference on this topic.

Prematurity, highly associated with the absence of prenatal care in low-income mothers, is another important factor in mental retardation. Monitoring of the fetus during gestation and delivery has promise for early detection of complications and initiation of intervention procedures. Collaboration between obstetricians and developmental specialists in the conduct of longitudinal studies may shed new light on the relationship between obstetrical events, social environmental forces, and later intellectual development.

The poor learning performance of many children is secondary to various sensory and motor deficits. On the principle that each sensory system within the body interacts with and is modified by other sensory systems, tests have been developed to measure integration of two or more sense modalities. Preliminary assessment of these techniques shows a high correlation with reading ability and IQ, suggesting a possible culture-free test of intelligence. Studies of the integration of sensory systems bear directly on the extensive problem of minimal brain dysfunction and on basic developmental processes.

Relatively little is known about the physiological basis for learning. Neurochemical and neurophysiological studies are attempting to learn more about how

memories are acquired, stored, retrieved, and utilized, and about some of the biological bases of communication difficulties.

Little information is available on the frequency and distribution of specific disease or diagnostic entities, personality traits, demographic characteristics, and other variables in the mentally retarded population. Such data can help to define relationships between presently obscure sociocultural and psychological factors and disease and pathologic processes. The collection of data is currently underway on over 24,000 patients in public institutions. To further advance research activities in this area, the Institute recently sponsored a small conference of leading epidemiologists and related scientists interested in mental retardation.

2. National Institute of Neurological Diseases and Blindness: The National Institute of Neurological Diseases and Blindness has a variety of research projects directed at the many facets of the neurological disorders of infancy and childhood. Many of these projects deal with mental retardation where it appears as a symptom, complication, or sequela of a disorder of the central nervous system.

The National Institute of Neurological Diseases and Blindness is engaged in a collaborative project with fourteen cooperating institutions, investigating the prenatal, perinatal, and postnatal factors relating to the development of children. The "Collaborative Study in Cerebral Palsy and Other Neurological and Sensory Disorders in Infancy and Childhood" is following the offspring of more than 50,000 mothers from early pregnancy through labor and delivery until the children are at least 12 years of age. The final baby has been born to this project and the first stages of analysis may now be completed. This project should yield an enormous amount of valuable information related to mental retardation.

The Institute is also supporting many other individual projects related to these areas, which will yield important insight into the normal development and functioning of the central nervous system as well as the factors leading to mental retardation during gestation, infancy, and childhood.

a. Prenatal Studies

Epidemiological and genetic studies are being carried out in an attempt to establish possible patterns of inheritance or other causative factors leading to neurological disease and mental retardation. These include inborn errors, chromosomal abnormalities, and congenital malformations.

Inherited diseases are among the leading causes of mental retardation and represent the "inborn errors of metabolism." These may be abnormalities of carbohydrate, protein, or lipid metabolism. The Institute has initiated a program of study of these diseases in order to understand their basic nature as well as their role in the resulting mental retardation.

Chromosomal abnormalities and congenital malformations continue to receive Institute-supported attention. Efforts are directed at establishing the causes of these abnormalities, and hopefully, developing methods of prevention. The possible role of physical agents as drugs and poisons is also receiving direct attention.

Intrauterine infections are important factors leading to severe destruction of the brain and major mental impairments. Special interest is directed at the role of viruses, including Rubella (German Measles) and Cytomegalic Inclusion Disease, and at the role of the fungus *Toxoplasma gondii* in producing neurological damage. Particularly important are efforts to produce a vaccine for Rubella (German Measles), which may cause congenital abnormalities in the offspring when the mother is infected during the first trimester of pregnancy. At the Laboratory of Perinatal Physiology in Puerto Rico, studies of pregnant monkeys are being carried out to see if this disease has the same effect in primates, and if so, whether this laboratory model can be used for a variety of tests.

b. Perinatal Factors

As noted above, the Collaborative Study has completed its pre-and perinatal phases. Data analysis will soon provide information relevant to the events of labor and delivery.

Reparding inborn metabolic errors, many States are now requiring tests in infancy for phenylketonuria, an example of this kind of disease. Many children will be examined in infancy and followed through childhood in order to relate early diagnosis to the effectiveness of therapy. Through research of this kind, it is hoped to discover how early these diseases do appear and when to begin

treatment. There are more than 200 known metabolic abnormalities, of which no more than 6 may be amenable to present therapeutic approaches. Continued study is necessary to enlarge these treatment programs. The biochemistry of these diseases and the relationship of the biochemical activities to brain function are being studied. This may elucidate their role in the development of mental retardation.

c. Postnatal Studies

The examination of the brain-injured child is becoming more important. From a wide variety of causes, many children have minor degrees of brain injury which can markedly affect their development. Studies are under way linking the pathological patterns of brain damage to functional development. Again the Collaborative Study will be increasingly valuable in providing both normative data and incidence statistics relative to mental retardation.

Mental retardation is a potential sequela of meningitis or meningoencephalitis. Institute programs are investigating the mechanisms involved as well as proper preventive and therapeutic approaches.

The early diagnosis of mental retardation is at times fraught with difficulties. The Institute continues to support programs for the refinement of diagnostic techniques. The problem of minimal brain dysfunction is undergoing re-evaluation to assess the current status of and to apply advanced techniques to this difficult area.

Mental retardation is often a sequela of hydrocephalus and brain tumors in childhood. The development of appropriate surgical or pharmacological therapy remains an objective of the Institute.

The National Institute of Neurological Diseases and Blindness is directing its efforts at a number of other disease problems not specifically or necessarily involving mental retardation. However, the results of these studies may provide clues or answers to the various facets of mental retardation.

d. Epilepsy and related paroxysmal disorders

Epilepsy and the related paroxysmal disorders comprise a large disease category associated in many instances with mental retardation. The National Institute of Neurological Diseases and Blindness is planning a large-scale effort relating to epilepsy, including cooperative efforts with several clinics studying methods of diagnosis and treatment as well as basic research into the mechanisms of seizures.

e. Sclerosing disorders

Sclerosing disorders of the nervous system occur both in infancy and adulthood. Some of these diseases are lengthy and progressive, leaving the patient incapacitated and unable to care for himself. When these occur in infancy, mental retardation can result. Here, studies on the etiological relationship of viral, immunological, chemical, or genetic factors are being carried out.

f. Basic studies of the neurological and sensory systems

Mental retardation involves malfunction of the nervous system. Therefore, the basic research relating to the structure and function of the central nervous system which is being carried out by the grantees of the National Institute of Neurological Diseases and Blindness may ultimately be important in understanding the processes involved in mental retardation, its prevention and therapy. Studies in a wide variety of disciplines are included: electro-physiology, neuroanatomy, neurochemistry, general physiology, cerebral blood flow, and neurocontrol mechanisms, and studies on vision, hearing, and integrative activities of the nervous system relating to learning, memory, and behavior.

g. Disorders of communication

In addition to the basic studies mentioned above, many investigations are being carried out which relate to the integration of speech, hearing, and language. The Institute program is very large, embracing all facets of this wide field.

3. National Institute of Mental Health: A major goal of the Intramural Research Program of the National Institute of Mental Health is to discover the physico-chemical bases for the mental behavioral processes mediated by the nervous system. Such research involves not only psychological study of the impact of experience on the individual's capacities, but also detailed investigation by chemists and molecular biologists of the biological characteristics of the

individual. Some studies of both kinds focus on mental retardation, since it is a pathology of mind and behavior, often reflecting underlying pathologies of the nervous or endocrine systems.

In previous years, members of the National Institute of Mental Health staff have discovered the nature of the metabolic lesion in homocystinuria (of which mental retardation is a symptom), have traced out the chemical changes responsible for phenylketonuria, have discovered how thyroid gland secretions affect differentially protein, (i.e., brain cell) formation in infants and adults, and have contributed in many ways to knowledge of the processes of normal and abnormal psychological development.

The following are brief illustrative summaries of relevant research projects conducted by the National Institute of Mental Health:

Studies of the effects of thyroxine on protein synthesis in the adult and neonatal brain have revealed one of the basic processes involved in the mental deficit associated with cretinism. Progress has also been made in research on the biochemical mechanisms of several enzymes associated with maturation of the brain and of myelin synthesis in the developing brain. These studies are important for understanding the underlying biochemical reactions which may be deranged in many other types of mental retardation.

Investigations of the processes by which cerebral blood supply is established in the developing brain are basic to an understanding of cerebral development and to those forms of mental retardation in which maldevelopment of the brain is a factor.

A number of studies attempt to assess the processes involved in the metabolism, storage, and mechanism of action of catecholamines. Evidence continues to mount that these processes are important in influencing the physiology, pharmacology, and pathology of the brain, and that they may be involved in the development of intellectual capacity.

The study of metabolic abnormalities in homocystinuria is being carried out in collaboration with the National Institute of Arthritis and Metabolic Diseases. Biochemists working in the area are carrying further their analysis of the nature of the biochemical lesion involved in the condition, with the expectation that once these biochemical processes are fully understood, preventive methods can be designed to deal with the mental retardation associated with the disease and effective methods of treatment can be developed.

An experimentally-induced encephalitis similar to that which appears to cause brain damage and resulting mental deficiency in childhood has been studied extensively in laboratory animals and effective immunological techniques for suppressing the experimental disease have been developed. The possibility of neutralizing the harmful effects of the immunologic reaction even after onset of signs of disease is now being investigated.

Neurophysiological research on the activities of individual cortical neurons and on the effects of cortical damage on physiology and behavior function is continuing. Findings may have implications for the study of mental retardation and for the rehabilitation of brain-damaged retardates.

Biochemists, studying metabolic systems in relation to mental illness, had previously demonstrated that phenylketonurics are missing an essential enzyme which affects their ability to convert phenylalanine to tyrosine and results in mental retardation. Recently other investigators have reported that all new-born animals tested, including humans, lack this enzyme at birth and that, for the first few days of life, most and perhaps all animals suffer from the same metabolic defect as do phenylketonurics. The National Institute of Mental Health investigators who re-examined the problem have found, in sharp contrast to these reports, that the enzyme is quite active in all the new-born animals tested.

4. Division of Mental Retardation: A study sponsored by the Division of Mental Retardation is underway in Maryland to develop new, palatable recipes which can be used for phenylketonuric diet. Three applied research projects are being carried out by the Division in Israel, using counterpart funds. One of the projects is studying thyroid conditions and treating retardates with thyroidactive substances to study the effect in amelioration of mental retardation. The second is aimed at the improvement of the accuracy of diagnosis of mongolism at birth for purposes of counseling and care planning. The third is an epidemiological study of mongolism in the greater Tel Aviv area.

5. Bureau of Health Services: A pilot study by the Division of Indian Health in cooperation with the Bureau of Indian Affairs is in process which utilizes

an interdisciplinary approach to identify both organically and functionally retarded children. The medical, psychological, and sociological screening of these children provides a diagnostic basis for determination of required medical treatment and specialized curriculum to meet individual learning needs. Other activities of the Bureau of Health Service include:

A study in process in the Phoenix Area designed to determine the cause and methods of prevention of prematurity among Indian infants (there being a high correlation between prematurity and mental retardation).

Research conducted in the Public Health Service hospitals on metabolism and the endocrine systems, disorders of which may lead to mental retardation.

A special five-year study in conjunction with the National Institute of Dental Research, concerned with congenital malformations among Indian infants born in Division of Indian Health hospitals.

A five-year study on Alaska infant mortality and morbidity, completed in 1964, but extended through calendar year 1966 for the purpose of continued study and follow-up.

B. *Research concerning functional mental retardation.*—1. National Institute of Child Health and Human Development: The National Institute of Child Health and Human Development is supporting research into the psychosocial and cultural aspects of mental retardation as manifested in impairments of learning, adaptive behavior, and physical and intellectual development. The following are illustrative of the studies supported:

The large majority of the retarded are members of disadvantaged families. They generally live in city or rural slums, lack cultural and educational opportunities, are products of broken homes and frequently are members of ethnic and racial minority groups. Such children have little opportunity to explore the world about them, fail in school, lack self-confidence, and are poorly prepared to cope with adult responsibilities. Precise information is lacking regarding the factors within the "cultural deprivation" syndrome that distinguish the retarded from social class variables related to motivation, family interaction patterns, communication styles, peer influences, and the impact of social and economic conditions. Studies to obtain this information have been undertaken, the success of which is crucial to effective prevention and treatment programs.

The early identification of functionally retarded children or of those vulnerable to retarded performance at school age is a prerequisite to intervention programs. Present studies indicate it may be possible to assess learning capabilities very early in life. Thus, future research objectives may be directed toward developing techniques for early diagnosis refining evaluations of learning potential, and devising remedial approaches.

A major thrust of the Institute's program in functional retardation is related to prevention and treatment through environmental enrichment for preschool-age depriced children. Many studies have demonstrated that preschool education techniques can accelerate IQ scores in children but that these gains are generally not sustained as the child grows older. One investigator is promoting early child education and training through parent-child interaction. In this study, mothers are given instructions and provided with lesson "kits" and are involved in the teaching of other children. The mothers are especially guided toward positively reinforcing the child's progress through praise and encouragement, attitudes which do not characterize their relationships with their own children. Parent-child teaching and training, it is hoped, may be one answer to breaking the self-perpetuating cycle of cultural deprivation and preventing further deficits from occurring.

Motivation and incentive techniques are being applied to remedial instruction programs to combat the commonly noted lack of motivation in deprived children. Incentive points, which can be traded for valued goods or experiences, are offered for homework and grades earned. Significant academic progress among deprived children, including a group of junior high school drop-outs who were members of the local neighborhood Youth Corps, has been observed. Operant conditioning methods utilizing a token reward system have also been applied successfully with severely retarded institutionalized young women in motivating more adequate self-care behavior.

Intrafamily relationships are of paramount importance in the socialization of children and in the acquisition of communication and language skills. Studies supported by this Institute indicate that in deprived families there is limited verbal interaction between parent and child and a style of communication that poorly prepares the child for the school setting or for daily problem-solving.

Some language development and communication behavior is indispensable to learning, and therefore studies of the processes involved and their possible modification have great potential for advancing the retarded child's learning skills.

Research into the area of learning is proceeding along many paths. Subjects now being studied include discrimination learning patterns; intersensory integration; perception, conditioning, and measurement of attention response; remedial instruction materials and techniques; teacher attitudes and capabilities; and others. The importance of learning impairment in the formation of the child's self-concept, personality, and coping behavior points to the significance of this area of research.

The management and care of retarded children is highly dependent on parental attitudes and understanding. Parent counseling is widely applied toward improving attitudes and understanding, but little analysis has been made of this interpretative and therapeutic process. One study indicates that the outlook of parents promotes misunderstanding in relaying necessary information to the counselor and that counseling "styles" may promote better parental estimates of their child's future social adaptation. Further investigations in this area may provide clues for promoting greater parental understanding and realistic management and guidance of the retarded child.

Environmental deprivation may have physiological as well as functional consequences for the mentally retarded. Experiments with animals indicate that environmental manipulation can alter brain weight and various biochemical systems and affect central nervous system development. Such studies have important implications for learning and development in deprived children.

In addition to research focused on mental retardation per se, the National Institute of Child Health and Human Development supports a broadly based program of research in related aspects of human development, embracing the entire life span from preconception through old age. Many of the studies in reproductive biology, in the biological and behavioral aspects of growth and development, in perinatal and infant mortality have relevance to mental retardation.

2. National Institute of Mental Health: The National Institute of Mental Health extramural grants program emphasizes basic and applied research in three major aspects of mental retardation processes of learning, sociocultural influences, and psychiatric, or behavioral implications.

a. Processes of learning

Knowledge on processes of learning in retardation is sought not only to provide diagnostic understanding but to chart the way toward more effective remedial techniques. Basic researches in learning include a variety of experiments dealing with the retardate's pattern of paying attention, the effect of reward on learning, conditioned responses to meaningful events, learning by association, and differential abilities to deal with varying materials.

One investigation is studying methods of increasing the attentive ability of retardates by varying the quality and timing of reward for attention. Another is experimenting with the effectiveness of social, verbal, visual, and other forms of rewarding reinforcement on behaviors other than attention, such as remaining at a task and aspiring to do well in learning situations. The use of machines to dispense rewards for self-help skills such as toileting, dressing, and communication is being studied. Conditioning of responses holds promise as one approach to helping the retardate cope more effectively with everyday stresses. By a series of experiences in successful adaptation of a type of encounter, the retardate may be prepared to respond to subsequent natural encounters of the same type, even without having to stop and weigh the situation, so that conditioning may be carried out with more predictable results. Experiments are underway to clarify the characteristics of basic, classical conditioning with very young retarded and normal children. An approach applying programmed learning to reading skills is being tested by one investigator. In comparing experimental classes of retardates using the programmed reading method with classes using current school methods, the investigator has found so far that the children receiving programmed instruction not only developed greater reading skills but gained also in attention span, frustration tolerance, social skills, and general vocabulary. Another project is extending the programmed teaching methods beyond reading to writing and arithmetic.

b. Sociocultural influences

A number of projects deal with the environmental circumstances of retardates. The concern is not only with the impact of the environment on the retardates

mental ability, but extends to his ability to adapt to environmental circumstances in his normal community.

One demonstration aims to find out to what extend diagnosed educable mentally retarded children can be helped to participate in group activities for normal children. Observations are directed toward learning what characteristics a child must have in order to interact successfully with his normal peers, what social group work leadership skills are required, the kind of satisfactions or frustrations he and his parents experience, and the administrative rearrangements an agency must make to accommodate such children.

In a State which has just opened a new institution for the retarded, advantage is being taken of the opportunity to assess the consequences of remaining within the natural cultural milieu compared with those of entering an institution. Comparisons will be made between cohort groups that are admitted against cohorts that are not, on demographic, psychological, and medical indices. The results should provide information on the wisdom of constructing further institutional beds, but also they will clarify the influence of natural cultural experiences relative to the influence of the institutional cultural on the adaption skills of the retarded person.

The work of a number of investigators is devoted to experimental explorations of the impact of cultural deprivation on subsequent emotional and intellectual development. Deprivations associated with such social problems as poverty, inadequate schooling, and community disorganization are found to be major factors in the development or exacerbation of mental retardation. Some investigators are attempting to determine whether foster home care will overcome the retarded behavior of children reared in institutions from infancy, while others are contrasting the effects on intellectual development of various types of home and community environments.

c. Psychiatric implications

Increased regard is being given to the behavioral skills of retarded children. Preoccupation with intellectual deficit has often occluded the fact that the ability of the retardate to handle life situations is influenced markedly by his behavioral characteristics. Researches are being conducted to determine the optimum manner of relating to a retardate, to discover the role of reinforcement in bringing about more effective reactions, and to discover how to identify unnoticed personality assets and to predict behavior characteristics later in life.

Other projects designed to test methods of helping the retardate acquire effective behavioral adjustment to life involve multi-disciplinary assistance in non-residential settings, special techniques for children whose retardation is complicated by blindness, reduction of the untoward effects of custodial experiences, the use of volunteers in modifying behavior patterns, and the application of learning theory principles in the development of greater self-sufficiency.

d. Other research relevant to functional mental retardation

The National Institute of Mental Health intramural studies being carried out principally by psychologists include: investigation of the ways in which preschool children develop the concepts which make possible an understanding of the world around them and the learning of complex relationships; study of the impact on culturally deprived infants of intellectual stimulation during the period of early verbal development; and the development of methods of observing and analyzing the behavior of three- and four-day old babies with the objective, among others, of learning to identify early and mild mental retardation. (There is generally no problem in the diagnosis of severe mental retardation.)

The Institute also provides grant support for a number of areas of research which, although not directly focused on mental retardation, provide research findings which stimulate the development of new methods of diagnosis, care, and treatment applicable to the retarded. Research on closely related disorders in childhood contributes to understanding the environmental causes of mental retardation. The developmental research program provides data on the physiological, psychological, and social growth of the normal child, against which deviations in the mentally retarded child can be understood and measured.

Studies of the diagnosis and treatment of childhood autism and other childhood behavior disorders contribute knowledge which helps to discriminate between those children with intellectual deficits and those suffering from emotional difficulties. Because certain psychopathological states such as childhood autism result in a gross intellectual deficit, research being conducted on this

problem is helping to provide the means to differentiate accurately between retardation and emotional illness.

The National Institute of Mental Health also supports a number of studies on basic problems of learning, perception, cognition, emotion, motivation, personality, and language, all of which have relevance to understanding and treating mental retardation. For example, studies of the child's intellectual functioning in school yield information not only on how to enhance the intellectual potential of the normal child but also on how to aid the mentally handicapped child. Basic study of the cognitive processes in children provides information essential to investigators developing methods for more effectively teaching the mentally retarded. A study of language disorders in aphasia has led to ideas for identifying and assisting the child who may be labeled "retarded" but is in fact suffering from a learning problem.

C. *Other Public Health Service mental retardation research activities.*—1. Two Branches and one Laboratory have been organized to carry out direct research activities in mental retardation. These include a Children's Diagnostic and Study Branch, a Laboratory of Biomedical Sciences, and a Behavioral Biology Branch.

The Children's Diagnostic and Study Branch is operational and is located at the National Naval Medical Center. The purpose of this Outpatient Clinic is to provide a program of clinical research and a source of case material for basic research in the biomedical and behavioral aspects of mental retardation. Currently, two new patients are being evaluated each week by a multidisciplinary team. The Clinic team is interested in studies on learning. A small nursery school is associated with the Clinic and will provide an ideal setting for studies of learning, motivation, and teaching procedures. Specific studies are being carried out on improving attending behavior in preschool retardates; behavioral assessment in a free-play situation; and operant conditioning audiometric techniques.

A Laboratory of Biomedical Sciences has been collaborating with other Institutes on specific projects. Construction is proceeding to renovate space for biomedical and behavioral research laboratories at the National Naval Medical Center, adjacent to the Children's Diagnostic and Study Branch to facilitate collaboration between clinicians and laboratory investigators. This facility will be ready for occupancy early in 1967. The Biomedical Sciences Laboratory will combine the disciplines of genetics, developmental enzymology, and intermediary metabolism in studies centering around an investigation of the inborn errors of metabolism.

A major objective of the Behavioral Biology Laboratory is research designed to improve understanding of the biological mechanisms underlying memory and learning, and to utilize this understanding as a basis for developing specific decisive methods for enhancement of these functions. The Laboratory is developing research on neurophysiological methods for diagnosis, evaluation, and treatment with the objective of improving our understanding of those aspects of brain function and cerebral pathophysiology relevant to mental retardation.

2. Contract research activities in 1966 included a project with the Western Interstate Commission for Higher Education. This project is for the purpose of collecting epidemiologic data on retardates served by the residential institutions in the Western States and for expediting communications and research exchange between these institutions. In 1966, twenty-two institutions participated in the data collection effort.

3. Within the National Center for Health Statistics the Health Examination Survey is collecting information concerning various aspects of growth and development, utilizing a probability sample of the nation's children and youth. Included in the measurements of growth and development are abbreviated measures of intellectual functioning.

Collection of the basic data on the sample of children at ages 6–11 years has been completed and examinations are underway on the sample of youth between the ages of 12 and 17 years. The data collection phase will not be completed until calendar year 1969.

Because estimates of intellectual functioning will be based upon abbreviated portions of standardized intelligence tests, methodological studies will be conducted which will be aimed at optimizing the obtained estimates. To do this, a sample of persons will be given the traditional, standardized intelligence tests as well as the abbreviated measures utilized by the Health Examination Survey.

In order to provide meaningful data regarding the prevalence of mental retardation in the population on non-institutionalized children living in the United States, the first of these methodological studies will be conducted on a population of children which includes a number of known retardates.

V. Construction

A. *Community Facilities for the mentally retarded.*—The Mental Retardation Construction Program provides Federal grants to States for assistance in the construction of specially designed public and other nonprofit facilities for the diagnosis, treatment, education, training, or custodial care of the mentally retarded, including sheltered workshops which are a part of facilities which provide or will provide comprehensive services for the retarded.

All States are participating in the program. To date, over 100 projects which will provide better services in modern facilities to more than 12,000 additional retarded persons, have been approved for Federal assistance. Approximately 50 percent of these projects will provide day services, 30 percent residential care, and 30 percent diagnostic and evaluation services. Several projects provide more than one type of service. Some 150 additional projects are in various stages of development for submission for approval.

The program is beginning to have impact on meeting the needs of the retarded. Public and voluntary agencies are manifesting increased interest in participating in the construction program, and community leaders and professional personnel are combining efforts to stimulate sponsorship of needed facilities. Accomplishments to date, however, have merely touched on the need for additional services and facilities. State plans indicate that services should be provided for more than one million additional retarded individuals.

B. *University-Affiliated Retardation Facilities.*—The construction program for university-affiliated retardation facilities is designed to provide the physical setting for training efforts needed to alleviate the acute shortages of professional and technical personnel (e.g., physicians, nurses, psychologists, speech therapists, and educators) required to care for the metally retarded.

Future goals included the stimulation of projects to be sponsored by those universities and colleges best equipped to operate programs of training for needed professional and technical personnel, and the development of acceptable projects in geographic areas now lacking adequate training facilities. These training programs represent the best insurance for production of needed professionals and technicians in sufficient numbers to staff the many community-based facilities for care of the mentally retarded which are to be constructed.

C. *Mental Retardation Research Centers.*—Research and research training in mental retardation and related aspects of human development present unique demands in terms of facilities and resources. Recognition of these needs led, in 1963, to legislation authorizing construction grants for facilities in which biological, medical, social, and behavioral research relating to human development could be conducted to assist in finding the causes and means of prevention of mental retardation and, for finding means of ameliorating its effects.

The Mental Retardation Research Centers Program in 1966, its fourth year of operation, made Center awards to five institutions. With the two Center awards made in 1964 and the three awards made in 1965, the total of Centers awarded through 1966 is ten. In addition, two other Center applications were recommended for awards.

The Centers constructed through this program will provide research facilities in particular environments where a cohesive program of research and research training can be accomplished. Most of the centers are large complex facilities in settings where a broad spectrum of research on mental retardation can best be carried out. A small number of specialized centers which have a concentrated scientific focus on a particular aspect of mental retardation are also supported by the program.

The five 1966 awards were made to the University of California, Los Angeles, California; University of Kansas, Lawrence, Kansas; The Children's Hospital Medical Center, Boston, Massachusetts; University of North Carolina, Chapel Hill, North Carolina; and The University of Chicago, Chicago, Illinois.

The Center at the University of California at Los Angeles will have as its major focus a combined biological and behavioral approach to the problem of mental retardation. The research program there envisions cooperative studies among the Departments of Psychiatry, Neurology, Pediatrics, Biochemistry, and

other Divisions within the Medical School, as well as the Departments of Sociology and Psychology. Collaborative studies of a basic and clinical nature related to mental retardation will be undertaken. The Center will have rich resources of scientific consultation and clinical patients through close working relationships with the Neuropsychiatric Institute, the Brain Research Center, a recently approved University-Affilitated Facility for training and demonstration, and the Pacific State Hospital.

The Children's Hospital Medical Center, Boston, Massachusetts, is closely affiliated with the Harvard Medical School. The Mental Retardation Research Center at Children's Hospital proposes an interdisciplinary research program directed toward the understanding, prevention and amelioration of the handicapped and the mentally retarded. The research team of this Center will include representations from experimental neurological sciences, behavioral sciences, genetics, metabolism and clinical research. A University-Affiliated Facility for the metally retarded has been awarded to Children's Hospital Medical Center and will complement the programs of the Research Center as well as providing a source of ambulatory patients for clinically oriented research.

The University of Kansas Center will be composed of three geographically separate units linked administratively into a comprehensive, integrated program of research. One unit, at Parsons State School, Parsons, Kansas, will provide an institutional research base where basic research and applied research on institutionalized retardates can be conducted. Another unit at the Kansas University Medical Center, Kansas City, Kansas, will include studies of reproductive physiology, biochemistry, neurophysiology, and fetal and neonatal pathophysiolgy. Studies on learning, languages, and social behavior will also be conducted there. The third unit is on the University campus at Lawrence, Kansas, where research will feature basic child development studies with an emphasis on socialization, communication, and learning. Staffs of each of these units have had long-standing commitments to research on mental retardation. The long-range plans of the Center administration envisions a broad, multidisiciplinary attack on the problem of mental retardation through the coordinated efforts of the staffs of the three units.

The Mental Retardation Research Center at the University of North Carolina, Chapel Hill, North Carolina, will consist of two highly coordinated research facilitiles working with a broad interdisciplinary approach to research with retarded and potentially retarded children. The Medical Center Facility will be largely oriented toward the medical and biological aspects of mental retardation, emphasizing the development and maturation of the nervous system and the genetic and biochemical factors which affect its proper functioning. The Frank Porter Graham Research Center facility will be a functional part of an existing elementary school and will be oriented toward social, psychological, and educational studies, particularly those concerned with the effects of early cultural and emotional enrichment upon young children from a population with a high incidence of mental retardation. Provisions will be made for programmed day care of the children from the age of infancy through the preschool years.

The children will be under close observation and special programming through the elementary school years. Medical studies, including follow-up of obstetrical events, infectious diseases, and factors of concern to pediatrics and public health, will be included in the program of long-term, longitudinal investigation of the children in the Frank Porter Graham Facility.

The University of Chicago's Wyler Children's Hospital, Chicago, Illinois, was given a moveable equipment award to aid in a progrem of research involving cytogenetics, neurologic investigations, experimental embryology, virology, and biochemistry.

On application, Program Project Grants may be awarded to awardees of Centers. These grants provide operational support for a Mental Retardation Research Center's comprehensive research program. Four Centers were awarded such project grants in 1966.

VI. State Coordination

In October 1963, the "Maternal and Child Health and Mental Retardation Planning Amendments of 1963" (P.L. 88–156) authorized a total of $2.2 million to be made available to the States for planning to combat mental retardation. Of the 55 eligible jurisdictions, 53 participated in the program (Guam and American Samoa being the only exceptions). Initial planning took place during 1964 and 1965 and was completed by December 31, 1965. This activity resulted

in published plans—amounting to blueprints for action—in each of the 53 States and jurisdictions.

The "Social Security Amendments of 1965" authorized grants of $2.75 million a year for 1966 and 1967 to assist States in needed continuation of planning and in the implementation of their comprehensive plans. Although funds were authorized for two years, planning and implementation activities can be carried out through June 30, 1968. The additional 6-month period will allow the States much greater flexibility in overall programing.

Under the current planning and implementation program, 50 of the eligible 53 States and jurisdictions have received $2.12 million. Three States are in the process of submitting applications for funding under this program. In the period January 1, 1967 through June 30, 1968, funds in the amount of $3.38 million are available from the Division of Mental Retardation for the planning and implementation program.

Although results vary greatly in the individual States, many examples of progress are already available. Stress has been placed on community planning in Colorado, North Carolina, Florida, and Nebraska. Division of a State into regions for better assessment and projection of programing is being emphasized in Illinois, Indiana, Connecticut, and Wisconsin. Special projects with emphasis on implementation objectives have been undertaken in California, Texas, New York, and Michigan. A summary of State activities in planning and implementation has been compiled, which, with other documents on special areas of interest in planning, will be published in 1967.

To weigh the impact of planning on a nationwide scale, a contract has been negotiated to collect, collate, and feed back the great variety of information becoming available in the published documents on original planning.

VII. Other Activities

A. The Division of Mental Retardation continues to distribute a documentary film about mental retardation stressing the value of a fixed point of referral in the community upon which the families of the mentally retarded can depend for continuing lifetime guidance and assistance in obtaining appropriate services. The title of the film is "Handle with Care." It is now placed in State health departments and medical school film libraries for wider distribution.

B. Since 1964 a mental retardation information activity has been operated as part of the National Clearinghouse for Mental Health Information. Because knowledge about mental retardation comes from many scientific disciplines and professions, this service will improve both research and practice and thus have a decided effect on the prevention and treatment of mental retardation.

To maintain this service, the National Clearinghouse for Mental Health Information, under contract with the American Association on Mental Deficiency, collects current literature on mental retardation, writes informative abstracts, indexes the literature in depth, compiles annotated bibliographies on special topics, and prepares critical reviews. Since 1964, a total of 4,900 current articles, books, and monographs have been collected, abstracted, and indexed. To provide a more extensive coverage of information for retrieval purposes, an additional 3,500 indexed abstracts of documents published from 1957 through 1963 were recently added to this system.

Special annotated bibliographies have been prepared on: (1) Programed Instruction with the Retarded; (2) Literature for Parents; (3) Application on the Stanford-Binet and Wechsler Intelligence Scales with the Mentally Retarded; (4) Nursing and Mental Retardation; (5) Family Care and Adoption of Retarded Children; (6) Psychotherapy with the Mentally Retarded; (7) Recreation for the Retarded; (8) Counseling Parents of the Mentally Retarded; (9) Sheltered Workshops for the Mentally Retarded; (10) Films on Mental Retardation; (11) Psychopharmacological Therapy with the Mentally Retarded; (12) Electroencephalographic Studies Relating to Mental Retardation; (13) Hydrocephalus; (14) Mental Retardation and Religion.

Review articles and critiques have been prepared on: (1) Mental Retardation; Definition, Classification, and Prevalence; (2) Research on Linguistic Problems of the Mentally Retarded; (3) Attendant Personnel: Their Selection, Training, and Role; (4) Research on Personality Disorders and Characteristics of the Mentally Retarded; (5) Effects of Severely Mentally Retarded Children on Family Relationships; (6) Factor Analysis and Structure of Intellect Applied to Mental Retardation; (7) Counseling Parents of the Mentally Retarded; (8) Genetic Aspects of Mental Retardation; (9) Instrumental Learning in

Mental Retardates; (10) Vocational Rehabilitation of the Mentally Retarded: The Sheltered Workshop; (11) Relationships Between Educational Programs for the Mentally Retarded and the Culturally Deprived; (12) A Decade of Research on the Education of the Mentally Retarded.

The abstracts, annotated bibliographies, and reviews appear in the quarterly journal *Mental Retardation Abstracts*, which is distributed gratis to approximately 5,500 individuals engaged in research and practice in mental retardation and is also for sale by the Superintendent of Documents.

Future goals include expansion of this service, particularly an increase in the coverage of the world's literature and research projects, improvement of the system for processing and disseminating available information, and provision of additional analytic and evaluative reviews of the state of knowledge in the area of mental retardation.

C. *Institutional and Case Statistics.*—1. Inpatient Facilities: Information is obtained from all inpatient mental retardation facilities, both publicly and privately owned, on the numbers of patients in various movement categories, as well as such patient characteristics as age, sex, medical classification, measured intelligence level for first admissions, and for resident patients. Also, from the public institutions for the mentally retarded, information is obtained on the personnel employed, by occupation, and the amount of maintenance expenditures for patients.

2. Outpatient Psychiatric Clinics: Information is obtained on the number of terminated patients diagnosed with mental retardation, by age, sex, and degree of deficiency (mild, moderate, severe), whether treated or not treated. Administrative and staff information (man-hours of professional staff by discipline) is also secured for clinics restricted to patients with mental retardation.

3. Annual administrative data, man-hours, type of services provided, estimated caseload, and weekly census are reported for day-night units and those with a consultant psychiatrist primarily serving mental deficients.

4. Maryland Psychiatric Case Register: Data are routinely collected on demographic patient characteristics, type of service, referral service, and disposition of all patients diagnosed as mentally retarded in all psychiatric clinics and public and private institutions for the mentally retarded.

5. Plans are underway to collect annual nationwide information which will include information about (a) inpatient facilities for the mentally retarded; (b) psychiatric clinics either serving or restricted to the mentally retarded; and (c) mental health clinics for the retarded which have regularly scheduled psychiatric consultation. Data collected will include: facility name; address; agency operating facility; operating schedule; programs and services provided; age and other special groups served; expenditures; number of patients served, including admissions, discharges, and other "movement" counts; and staffing patterns.

Administrative, staffing, expenditure and movement data collected in (a), (b), and (c) above will be superseded by this program. Data collection on age, sex, and diagnosis of patients will be continued with only minor revisions.

6. The National Institute of Mental Health has recently completed a special study of the outpatient psychiatric clinic experience of mentally retarded children completing clinic services during the year ending June 30, 1963. Data were collected on the source of referral to the clinic, the type and amount of service, and recommendations for further care of patients. Tabulations have been published in "Outpatient Psychiatric Clinics, Special Statistical Report, The Mentally Deficient Child and Psychotic Adult, 1963, State and Total United States."

D. *Record-keeping manual for inpatient mental retardation facilities.*—Now underway is the development of a manual on record-keeping for mental retardation facilities similar in format to "A Guide to Record-keeping in Mental Hospitals." U.S. Department of Health, Education, and Welfare, Public Health Service, October 1962.

Office of Education

INTRODUCTION

The Office of Education is the primary education agency of the Federal Government. It offers leadership in contributing to the process of shaping educational goals and policies to insure the optimum development of all our people. It identifies needs, makes studies, publishes reports, conducts professional con-

ferences, and provides professional and financial assistance to strengthen areas of education where there appears to be nationwide need.

The interest of the Congress and the executive branch in developing at the Federal level, a balanced approach to the problems of mental retardation has brought into sharp focus the importance of special education in an adequate overall program for the mentally retarded and the need for extending and improving special education programs in the schools of the Nation.

The enactment of title III of P.L. 88–164 created new programs and initiated the expansion of existing programs in the area of the education of mentally retarded children and youth.

I. Services

The Elementary and Secondary Education Act of 1965 (P.L. 89–10) provides in titles I and III the opportunity for school districts to develop creative educational programs for the mentally retarded.

The intent of title I is to focus attention on those areas with high concentrations of children from low-income families where educationally disadvantaged children are frequently found. The term "educationally disadvantaged" includes those children who are handicapped because of physical, mental, or emotional impairment. Studies have shown the relationship between educational and cultural deprivation and mental retardation, particularly in the upper ranges of the educable mentally retarded. Thus, an effort designed to work with children from low-income families who are culturally and educationally deprived will provide not only direct services to those who are already identified as mentally retarded but will also serve as a preventative measure if creative programs are developed for young children.

Title I makes provision for a wide variety of programs and services. The creativity in developing programs must originate at the local level. These plans are forwarded to State education agencies where they are reviewed for approval and on the basis of this approval, funds are distributed to carry out the various projects. The Federal Government's role has been to distribute funds to the States based on the formula included in the law and to develop policies, procedures, and guidelines for the States to use in approving programs.

Title III makes provision for two basic types of projects. The first calls for the provision of vitally needed educational services not available in sufficient quantity and quality. The second provision is for the establishment and development of exemplary programs which can serve as models for regular school programs. Title III provides the broadest kind of flexibility in that support can be given to virtually any program for the retarded that provides additional educational services or insures a continuing influx of tested innovation. Examples of projects would be diagnostic centers, preschool centers, the provision of psychiatric screening and referral, family casework, psychological screening, counseling, the development of instructional materials centers, and the conducting of model demonstration programs to illustrate to teachers, administrators and members of boards of education what can be done.

Applications for the funds available under title III are made directly to the Office of Education, Department of Health, Education, and Welfare. However, the applications are channeled through the State education agencies for review if the applicant is a local education agency.

The Elementary and Secondary Education Act has been amended by P.L. 89–313 so that funds are available for State-operated and State-supported schools for certain handicapped children for whose free public education the State is directly responsible. Schools for the mentally retarded are also included. The schools can be operated by any State agency. However, applications for funds under the provisions of P.L. 89–313 are processed through the title I Office of the State education agencies.

In fiscal year 1966, funds were allocated in behalf of 34,570 mentally retarded children. The children benefitting were in educational facilities for mentally retarded children in 45 States and the District of Columbia.

Reports on 1966 show that programs developed under these funds were used for improvement in diagnosis, curriculum innovation, extended day activities of recreation, and cultural enrichment. These were in-service opportunities for teachers and parent activities. Many additional classes were added. In some States, attention was given to the problem of multiple handicap. Many of these programs were conducted in the summer of 1966.

A sizable dollar authorization in the most recent legislation in this field—the new title VI of the Elementary and Secondary Education Act created under

P.L. 89–750 (the Elementary and Secondary Education Amendments of 1966)—is expected to make significant inroads in the education of handicapped children, including the mentally retarded. Under title VI, $50,000,000 in 1967 and $150,000,000 in 1968 is authorized for grants to the States to initiate, expand, and improve programs and projects for the education of handicapped children. Title VI also provides that all programs within the Office of Education which address themselves to special education, small be administered centrally through a bureau of the handicapped, created by this legislation. By bringing these service, training, and research programs into one point of focus, the whole area of the handicapped will receive the visibility, leadership, guidance and support necessary to carry out a concerted attack on the problem. Within this frame of operation, the National Advisory Committee on Handicapped Children, also authorized by title VI, will best be able to carry out that part of its statutory charge which requires it to review all educational, training, research and related programs for handicapped children administered by the Office, and to recommend improvements in their administration and operation.

Title IV, Part A, of the Library Services and Construction Act Amendments of 1966 (P.L. 89–511) provides for books, other library materials, and library services to be made available to students in residential schools for the mentally retarded which are operated or substantially supported by the State under approved State plans for establishing and improving State institutional library services. Appropriated funds for fiscal year 1967 are for planning purposes only. Previously, local public libraries have provided voluntary services to these individuals or arranged contract services to State institutions for the mentally handicapped—the new legislation will enable libraries to strengthen and sustain these services.

Under the Manpower Development and Training Act (P.L. 87–415, as amended) special programs have been set up to provide occupational training for mental retardates—two such programs have been developed in Maryland. Through a national contract with the Davis Memorial Goodwill Industries in Washington, D.C., individuals possessing all kinds of handicaps, including mental, are being trained. Ultimately, using an on-the-job training approach, some 386 persons will receive training in 24 occupations.

II. Professional Preparation

During the past 15 years, efforts to educate handicapped children have often been frustrated because of the severe shortage of trained personnel. The American people want handicapped children educated to their highest level. They have persuaded State legislatures to subsidize classes in public schools and have insisted on expanded programs. There have been, however, three major obstacles to the development of special education programs for handicapped children.

First, classroom space and diagnostic facilities have been lacking. Expanded enrollments in schools have taxed classroom space and school financing to such an extent that local school districts have had a difficult time finding funds and classroom space needed for special education.

Second, even when space is made available, superintendents are often unable to employ a sufficient number of qualified teachers to conduct the classes. It has been estimated that we need 200,000 teachers to man the classes for 5 million handicapped children. We now have 50,000 to 60,000 such teachers, most of whom obtained training through short summer courses, extension courses, and workshops. As a result, the majority of these teachers are either untrained or have only partial training.

Third, although many colleges and universities have, for some time, attempted to prepare teachers, supervisors, college instructors, and research personnel, this has been done with limited funds and facilities. It is to be noted that for every one professional person prepared in the education of the handicapped, four are needed.

In 1958, the U.S. Congress passed P.L. 85–926 which authorized an appropriation of $1 million a year for the training of professional personnel in the education of the mentally retarded. On the advice of consultants, the P.L. 85–926 graduate fellowship program concentrated on the preparation of instructors of directors in college and university programs for the education of the mentally retarded and supervisors and consultants of the mentally retarded in State and local school systems. From that date through academic year 1963–64, about 692 graduate fellowships were granted to 484 individuals. Of these, the majority have become college and university instructors, or State

and local supervisors and directors while some remained as teachers of the mentally retarded. This legislation was of inestimable value in the preparation of leadership personnel who will be staffing many of the college and university teacher-training programs in the education of the mentally retarded.

On October 31, 1963, P.L. 88–164 was signed into law. Section 301 of this act amends P.L. 85–926 to: (1) expand the program to include not only the area of the mentally retarded, but also the areas of the visually handicapped, deaf, crippled and other health impaired, speech and hearing impaired, and the emotionally disturbed; (2) allow for the preparation of teachers and other specialists in addition to leadership personnel at the graduate level; and (3) increase the money authorization for these purposes. Since P.L. 85–926 was amended in 1963, approximately 18,000 fellowships and traineeships were awarded for training in the various areas of the handicapped authorized under the legislation. Included in the 18,000 are about 8,000 in the area of the mentally retarded.

Under P.L. 88–164, $47 million was authorized for a 3-year period for the purpose of assisting institutions of higher education and State education agencies in the preparation of personnel in the education of the handicapped. Specifically section 301 authorized $11,500,000 for fiscal year 1964, in addition to the $1.5 million under P.L. 87–276 for training teachers of the deaf for fiscal year 1964; $14,500,000 for fiscal year 1965 to include teachers of the deaf; and $19,500,000 for fiscal year 1966. On August 4, 1965, P.L. 85–926 was further amended with the passage of P.L. 89–105, which expanded and extended the program until June 1969. The amendment under P.L. 89–105 authorized $29,500,000 of which $24,500,000 was appropriated for the fiscal year ending June 30, 1967; $34,000,000 for the fiscal year ending June 30, 1968; and $37,500,000 for the fiscal year ending June 30, 1969. These funds are and will be used as stipends for students in all areas of the handicapped and to assist colleges, universities, and State education agencies with the cost of instruction. Based on the 1967 appropriation of $24,500,000 over 9,000 additional traineeships and fellowships will be awarded to qualified individuals for training in the education of the handicapped. This includes over 3,500 in the area of the mentally retarded.

Under this program grants for the preparation of professional personnel are allotted to State education agencies and to public and private institutions of higher learning for:

Full-time traineeships (senior undergraduate); and
Full-time graduate fellowships;
Full-time summer session traineeships;
Full-time enrollment in institutions for advanced study;
Program development grants to institutions of higher learning to assist them in organizing programs for the preparation of professional personnel.

In 1964, State education agencies were allotted a minimum of $25,000 and a maximum of $100,000 for training professional personnel, based on a population formula. In 1965, State education agencies were allotted a minimum of $30,000 and a maximum of $110,000 for training professional personnel. In 1966 and 1967, State education agencies have been allotted a minimum of $50,000 and a maximum of $160,000 for training professional personnel.

Requests for Grants

The response to this grant program by the field has been overwhelming; over 300 institutions of higher learing, all 50 States, the District of Columbia, and 2 territories, submitted applications for grants-in-aid for training purposes. For fiscal year 1967 the requests for funds under this program exceeded the congressional appropriation by $31,000,000, or a ratio of more than 2 to 1.

Approved Grants-in-Aid for the Preparation of Professional Personnel

Committees of professional experts are appointed by the Commissioner of Education to evaluate and make recommendations on applications for training grants. Table I shows the numbers, types, and amounts of awards made in the various areas of the handicapped.

As a result of this program about 3,100 individuals are participating in training programs in the area of the mentally retarded during the academic year 1966–67. While this appears to be a substantial number, it is estimated that an additional 55,000 to 60,000 specialized teachers of the mentally retarded are needed.

III. Research and Related Activities

The Bureau of Research administers a number of separate legislative authorizations for research and related activities conducted outside the Office of Education, and funds from any of them may be used to support projects and programs related to the education of the mentally retarded. Some studies also are undertaken in cooperation with other agencies, such as those with the Office of Economic Opportunity to deal with the interrelationships between disadvantagement and retardation.

Background

Cooperative research, the oldest of the Bureau's authorizations for support of systematic research and related activities for the improvement of education, allocated approximately two-thirds of its initial 1957 appropriation of $1 million for research on problems of mental retardation. During ensuing years, cooperative research funds have not been earmarked for mental retardation, but by the end of fiscal year 1964, when the cooperative research annual budget had grown to $11.5 million, support for mental retardation research and related activities from this source had totalled $4.7 million, or 12.9 percent of the total funds allocated by the cooperative research program.

In the meantime, activities related to the mentally retarded also received support from authorizations for new media research and dissemination and from captioned films for the deaf in cases where these authorizations could appropriately be used. Beginning wih fiscal year 1964, authorization for specific support for handicapped children and youth research and demonstration brought categorical aid which could be used for activities for the mentally retarded as well as for other kinds of handicaps. The fiscal year 1965 authorization for vocational education research and training provided still another source from which some support could be drawn, in this case for activities related to career preparation of the mentally retarded. Support for research activities on the mentally retarded may be drawn from whichever authorization seems most appropriate for the study in question.

Procedures for Participation

Under the current Bureau of Research framework, which concentrates support for all extramural research and related activities into a single administrative unit, applicants are relieved of the need to tailor their proposals to a particular legislative authorization. All proposals follow the standard format outlined in the Bureau's brochure, "Support for Research and Related Activities," and the Bureau's research analysis and allocation staff assigns each proposal to appropriate staff for processing. This simplifies the application procedure and permits better use of funds especially in those cases where activities cut across related areas. To be eligible for consideration, activities must (1) show promise of contributing to improvement of education (2) have more than local applicability, and (3) be directed toward communicable results. Proposal evaluations by staff within the Office and by field readers and consultants from outside the Government are based on the following criteria: (1) educational significance (2) soundness of design or operational plan (3) adequacy of personnel and facilities, and (4) economic efficiency. Recommendations are transmitted to the Commissioner, whose approval is required for each project. Although applicants compete for available funds within a framework of priorities established by the Bureau and the Research Advisory Council, whose members are from outside the Office of Education, support for approved projects may come from any appropriate authorization.

Liberalization of eligibility for support and expansion of programs through recent legislation should considerably enlarge opportunities for planning and carrying out research activities related to improvement of education for the mentally retarded. To accommodate the wide range of supportable activities in all areas, the Bureau's support falls into two general patterns: Project support, which is appropriate for a wide variety of large and small research activities where the breadth of study and the amount of time are specified; and program support, which allows long-term commitments and continuous development and adaptability.

Project support is now available to individuals, local school systems, and public and private agencies, as well as to colleges and universities and State education agencies. In general, project support makes it possible for individual

researchers to develop and test promising innovations, for groups to develop curricular materials, for schools and school systems to study various programs and practices—in short, to seek objective answers to a multitude of important problems in education. Activities receiving support range from small projects ($7,500 or less in direct costs) to complex major investigations. Project support is also appropriate for the research component of operating programs, such as those under title III of P.L. 89–10.

Program support is used for research and development centers, educational laboratories, training of educational researchers, and in other appropriate circumstances. The comprehensiveness of operation and the need for continuity limits eligibility to responsible groups which are or can be organized so as to insure continued professional and fiscal responsibility and competence in keeping with the importance of supported programs. Activities related to the mentally retarded are suitable components for most operations seeking program support.

Applicable Specific Legislative Authorizations

The Cooperative Research Act (P.L. 83–531), as amended by title IV of P.L. 89–10, authorizes expansion of current programs of research, surveys demonstration and dissemination, support for the construction of facilities for research and research-related activities, and development and strengthening of programs for training educational researchers. This is the largest and most flexible of the authorizations administered by the Bureau of Research, and funds from it are used to support research projects and programs designed to expand knowledge about the educational process, to develop promising educational programs and techniques, to disseminate the results of these efforts to educators and the public, and to carry out other activities to assure continuous and systematic improvements in education at all levels and in all areas.

From an initial appropriation of $1 million in 1957, support through the Cooperative Research Act has grown to a fiscal year 1966 appropriation of $70 million, of which $20 million is for construction of regional facilities for research and related activities. Besides those projects and programs directly focused upon education of the mentally retarded, research which contributes to improved learning by all students will also contribute to improvements for those with mental handicaps.

Handicapped children and youth research and demonstration was started with a fiscal year 1967 initial appropriation of $1 million, authorized by title III, section 302 of P.L. 88–164. Amendment by P.L. 89–105, extends and expands this authorization to include establishment of a research and development center where efforts may be concentrated on continuous research and dissemination of findings related to improved education for the handicapped.

During fiscal year 1966, 92 new research and demonstration projects were funded. These and earlier projects are directed toward (a) translation of findings of research from the social and behavioral sciences into practical applications for the education of handicapped children and youth; (b) generation of programs and procedures for classroom teachers and education specialists which will make full use of known facts, ideas and theories; (c) creation of educational environments in which the implementation of new programs, procedures, and processes may be demonstrated; and (d) general improvement of the education of handicapped children and youth through innovations in learning situations as well as classroom procedures, methods, and materials.

The fiscal year 1967 appropriation of $8.1 million will be used for research and demonstration activities relating to the education of the mentally retarded, hard of hearing, deaf, speech impaired, visually handicapped, seriously emotionally disturbed, crippled, and other health impaired.

Funds authorized for media research and dissemination (title VII of National Defense Education Act, P.L. 85–864, as amended) may be used in two major areas: (a) Research and experimentation in more effective utilization of television, motion pictures, and related media for educational purposes; and (b) dissemination of information on new educational media. Included are studies involving development and evaluation of materials, pilot research in the educational uses of media, preparation and presentation of demonstration materials, provision of abstracts and analyses of research and experimentation related to media of communication for educational purposes, and studies on the planning production, and use of media in improving instruction in particular settings. Amendments also provide for consideration to printed and published materials to be used in conjunction with the new media. One of the areas under study has

been the development of instructional and remedial uses of new media. Within this category, research has been undertaken with specific application to the education of the mentally retarded.

The media research and dissemination program had an initial appropriation of $1.6 million in fiscal year 1959 and has a 1967 appropriation of $4.4 million. To the extent the mentally retarded learn from other media more effectively than they do from traditional printed materials, support from this program may be particularly appropriate for research and development activities to improve their education.

The authorization for vocational education research and training (P.L. 88–210, section 4(c), part A) is designed for research and development activities to help present and prospective members of the labor force acquire knowledge, skills, and personal characteristics necessary to insure satisfying work careers. The initial appropriation of $11.8 million in fiscal year 1965 was reduced to $10.0 million in fiscal year 1967. This relatively new legislation can be used for a variety of research, training and experimental-developmental-pilot programs, including those concerned with immediate vocational needs of dropouts, adults, disadvantaged, and slow learners.

Some Examples of Research and Related Activities

The State Department of Public Instruction at Lansing, Michigan is conducting a study to explore the relationship between the professional qualifications, experiences, and selected personality characteristics of teachers to the progress of trainable mentally handicapped children. The growth of approximately 600 trainable mentally handicapped children in about 60 classrooms will be observed and recorded periodically over a 3-year time span, according to the Cain-Levine social competency scale and other criteria. These data will be utilized to establish estimates of the growth of classroom groupings, which will be related to information concerning various aspects of teacher training, kinds and duration of teacher experience, and dimensions of teacher personality as estimated by the Leary interpersonal check list, the Edwards personal preference check list, and other instrumentation. An analysis of the findings could lead to principles of guidelines for the improvement of professional training programs and to criteria for teacher certification.

A project at the Oakland Unified School District, California is developing curriculum and instructional materials, for a "work experience and occupations" course for educable mentally retarded students. Development of training materials will assist educable mentally retarded youth in developing the vocational skills and attitudes necessary to obtain and retain jobs. The program will consist of three phases. Phase one includes a summer workshop to develop (1) job application visuals, (2) job description visuals, and (3) interest inventories at the third and fourth-grade reading level. Phase two will include implementation of new material in the "occupations" course and provide actual work experience for the students. Phase three includes evaluation and rewrite material as necessary in a workshop environment.

A number of projects focus on the development and evaluation of programmed materials with which to instruct retarded children. Dr. Leslie Malpass and his associates at the University of South Florida developed programs to teach reading and spelling, and they are now assessing the program's effectiveness in comparison with conventional classroom teaching. At the University of Nebraska, Drs. John Newton and D. T. Pedrini are determining the relative potency of various reinforcing contingencies upon learning under programmed instruction.

Dr. Alexander Thomas is studying 250 lower-class Puerto Rican children at the New York University Medical Center in order to identify experimental factors which are detrimental to optimal learning and those which can prevent or remedy environmentally induced retardation.

The need for public awareness about mental retardation gains recognition in the efforts of Dr. Henry L. Gottwald of Eastern Michigan University to survey a national sample on their quantitative and qualitative understanding of this condition.

To increase the effectiveness of professional teachers, the Wisconsin State Department of Public Instruction, under Dr. Kenneth R. Blessing, has a project to train and evaluate teacher aides under varying circumstances—large and small classes at the primary and intermediate levels.

Vocational preparation of the mentally retarded has been given a great deal of research. Dr. Clifford E. Howe of Long Beach, California, for example, is comparing the adjustment of retarded students who have had a three-year

involvement in work-experience training to those who have been in high school classes that are not work-oriented.

Dr. Sheila A. Ross, Palo Alto Medical Research Foundation, has been developing training programs that will improve the social interactions with peers of mentally retarded children. Her technique is referred to as "intentional training."

Vocational Rehabilitation Administration

I. Services

The Vocational Rehabilitation Administration administers a program of grants-in-aid to the States to assist them in providing rehabilitation services to people who are vocationally handicapped as a result of physical or mental disability. Among the services provided disabled people, including the mentally retarded, by State vocational rehabilitation agencies are a comprehensive medical, psychosocial and vocational evaluation, physical restoration, counseling, prevocational and vocational training, maintenance and transportation during the rehabilitation process, placement in suitable employment, and follow-up to ensure successful rehabilitation.

Of the 154,000 disabled people rehabilitated through the State-Federal program of vocational rehabilitation in fiscal year 1966, there were 14,293 with the primary disability of mental retardation, or 9.3 percent of the total number of rehabilitants in all disability categories, a significant rise from the comparable figure of 7.6 percent for fiscal year 1965. The estimated cost in Federal funds for achieving 14,293 rehabilitations was approximately $13,764,159. Looking ahead, it is projected that about 19,000 retardates will be rehabilitated through the public program in fiscal year 1967, at a Federal cost of about $23.1 million. In fiscal year 1968, these figures will go to 24,000 mentally retarded rehabilitated at an estimated cost of $31 million.

The Vocational Rehabilitation Administration also makes grants to State rehabilitation agencies for the purposes of expansion and innovation in order to improve rehabilitation services within a State. Expansion grants are designed specifically to increase the number of people rehabilitated such as providing for evaluation units and additional staff in rehabilitation facilities and workshops. Innovation grants provide the means for State agencies to develop new programs and techniques in order to adapt to changing needs.

The Expansion and Innovation grants have been utilized by the States in various ways. North Dakota, for example, initiated a project in 1966 to underwrite two staff salaries for a director and a social worker to expand services in a rehabilitation center. Indiana has a project to combine placement with an already existing training and evaluation program in a workshop which should increase placement 60 percent over the present operation. In an Innovation project in Minnesota a series of audio-visual aids for use in the rehabilitation and work preparation of mentally retarded persons has been developed. In Maine a person is to be employed as a coordinator of services aimed at placing mentally retarded clients in public employment.

State vocational rehabilitation agencies have been emphasizing three principal patterns of service in rehabilitating the mentally retarded. First has been the development of cooperative programs between State rehabilitation and education agencies in order to expand the scope of existing services and to introduce new programs for facilitating the transition of the retardate from school to work. Cooperative arrangements usually involve curriculum revision and improvement in the schools, a comprehensive evaluation of the vocational rehabilitation potential, the provision of personal adjustment and pre-vocational training as well as other rehabilitation case services, intensive counseling, on-the-job training, job placement, and follow-up. The direction and rehabilitation emphasis in these programs is given by the State vocational rehabilitation agencies and the educational direction comes through the school system. When available, community rehabilitation facilities for the mentally retarded are used for evaluation and occupational training and are an integral part of the pattern of services in these joint vocational rehabilitation-special education programs.

The vocational rehabilitation-special education cooperative program in Mississippi, for example, has continued to grow in size and effectiveness. In serving the 201 clients during fiscal year 1966, there were five counselors working in cooperation with 21 school systems. In California the State agency is operating vocational rehabilitation units in 30 independent school districts to serve mentally and physically disabled young adults. Twenty-five rehabilitation counselors are assigned to these programs and are being assisted by 70 members of the school district staff.

The second most important development has been the establishment of rehabilitation facilities to serve the mentally retarded which includes rehabilitation centers with comprehensive services, evaluation centers, occupational training centers, workshops, half-way houses, and other specialized facilities. Some of these rehabilitation centers are located in State institutions for the mentally retarded while others are located in the community. Rehabilitation centers may be operated by State vocational rehabilitation agencies, by the State agency in cooperation with other public agencies, and by other public or private agencies.

At Arkansas Children's Colony in Conway an increase in service to the mentally retarded was made available by the State vocational rehabilitation agency through the construction and staffing of a 40-bed evaluation facility. This facility has been operating at capacity during the entire year and now has a waiting list. During fiscal year 1967 and 1968 continued expansion is planned by doubling in size of the present evaluation facility including a workshop, dormitory space for 40 additional clients, and facilities for additional personal adjustment and training services. In Colorado, the State agency was asked to operate a sheltered workshop within the State Hospital, and consequently an addition of 14 people was made to the Rehabilitation Facility Center staff to implement this operation. This will be a sheltered workshop which will seek subcontracts from industry and provide employment for both the mentally ill patients in the State Hospital and those who are institutionalized because of mental retardation.

A third emphasis has been the assignment by State rehabilitation agencies of specially trained counselors and other specialized staff to work with the mentally retarded. Such specialized staff may operate in institutions or rehabilitation facilities for the retarded, or within the framework of coordinated special education-rehabilitation programs in school systems. This practice, which is already prevalent in most States, is expected to expand considerably in 1967, both as to the number of States employing specialists in mental retardation as well as to the number of specialists within a State where this pattern has already been established.

In Iowa, the rehabilitation unit at Glenwood State School for the Mentally Retarded got into full swing with a large increase in the caseload through the addition of a second full-time counselor plus a full-time speech therapist to provide speech therapy to those clients with the rehabilitation unit. A third counselor will soon be added to provide the full programming that is necessary within this unit. In a predominantly rural area in Wisconsin, one of the counselors is devoting full-time in the rehabilitation of the mentally retarded. This counselor has developed cooperative programming for the retarded in 30 small schools, has carried a caseload of 347 retarded clients, and has rehabilitated 53 mentally retarded in fiscal year 1966.

Under the program for Federal employment of the mentally retarded, which is jointly sponsored by the U.S. Civil Service Commission and the Vocational Rehabilitation Administration, State vocational rehabilitation agencies have the important function of certifying retardates as qualified for existing vacancies in Federal installations. Initially authorized for a two-year trial period, the program has proven so successful that the Civil Service Commission has extended it until at least September 30, 1968. With more than 30 Federal departments cooperating in the program, State rehabilitation agencies have succeeded in placing over 2,000 retardates in over 45 different types of jobs at Federal installations across the country.

Another significant step toward increasing substantially the number of mental retardates in competitive employment was taken in the fall of 1965 when a project was launched by the Institute of Industrial Launderers under a contract with the Bureau of Apprenticeship and Training, U.S. Department of Labor. Known as Project Manpower, it has the goal of providing on-the-job training leading to suitable employment in the industrial laundry industry for 1,000 mental retardates over an 18-month period. State vocational rehabilitation agencies are actively collaborating in this new program by evaluating, screening and referring mental retardates for the training opportunities established under Project Manpower.

A second effort of this kind was begun in February 1966 by the National Association for Retarded Children in which 1,500 mentally retarded are scheduled to be placed in on-the-job training with the ultimate goal of competitive employment. This Promotional Contract has involved several retail and food chains with not more than 300 trainees allotted to each. Woolworth's Sky Chef,

Federal Mart, and Howard Johnson's are some of the industries participating in the program. Financing and direction are similar to the IIL project mentioned above.

An additional resource having the potential for aiding further in the rehabilitation of the retarded is that provision of the Social Security Amendments of 1965 (P.L. 89–97) which permits payment from Social Security Trust Funds for rehabilitation services to selected categories of disability beneficiaries. These supplemental funds will be especially helpful to State vocational rehabilitation agencies in serving the Disabled Children Over Age 18 group, which contains many of the more severely retarded with varying periods of institutionalization and no past record of employment.

The Vocational Rehabilitation Administration has sponsored a number of special projects wherein the emphasis has been on services to a specific disability group or in a particular problem area. In many of these projects the population served has included the mentally retarded. Such projects would include those serving Selective Service rejectees, cooperative arrangements with educational systems, joint programs serving welfare clients, programs for offenders in correctional institutions, cooperative projects under the Manpower Development and Training Act, and those concerned with various aspects of mental health such as programs for emotionally disturbed youth.

State vocational rehabilitation agencies have also been cooperating in the formulation and development of the various State plans in the area of mental retardation authorized by recent legislation (P.L. 88–156 "Maternal and Child Health and Mental Retardation Planning Amendments of 1963"; P.L. 88–164 "Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963"; and P.L. 89–97 "Social Security Amendments of 1965"). The Vocational Rehabilitation Administration is collaborating with the Public Health Service and other concerned Federal agencies in reviewing these plans at both the Regional and Central Office levels. The Vocational Rehabilitation Amendments of 1965 authorize a two-year program of grants to States to plan for the orderly development of comprehensive vocational rehabilitation services, including services provided by private, non-profit agencies. These plans, which will involve careful consideration of the rehabilitation needs of the mentally retarded, have the objective of making vocational rehabilitation services available by 1975 to all handicapped individuals who need them in each State.

Special provisions have been made to assist States in meeting the cost of providing vocational rehabilitation services to handicapped individuals in order to determine whether they can reasonably be expected to engage in remunerative employment. In the case of the mentally retarded, such services may be extended over a period of 18 months. Previously, State rehabilitation agencies were expected to determine after an initial diagnostic evaluation, but prior to the rendering of any services, whether a handicapped person could reasonably be expected to become employable after his rehabilitation program had been completed. This new authorization will permit State rehabilitation agencies to accept an increased number of more severely retarded clients, and provide them with extended evaluative services in order to determine their real potential for ultimate employment.

II. Professional Preparation

The Division of Training administers a training grant program designed to increase the supply of professional personnel qualified to provide rehabilitation services. It is primarily concerned with: (1) grants to educational institutions to employ faculty or otherwise expand or improve their instructional resources (teaching grants); (2) grants to educational institutions for traineeships (stipends) to students; (3) grants to State vocational rehabilitation agencies for staff development (in-service training); and (4) contracts with educational institutions and agencies to support short-term training programs.

In fiscal year 1966 there have been 34 long-term teaching grants supported at 32 different institutions or organizations, including 28 leading universities. There were also 9 short-term training grants during this same period. The long-term grants support the professional education of specialists in social work, speech pathology and audiology, rehabilitation counseling and physical therapy. There were 235 traineeships in these areas awarded during fiscal year 1966 which included 8 traineeships awarded by the Research and Training Center at the University of Wisconsin. The short-term grants, with an emphasis on the vocational rehabilitation aspects of mental retardation, are basically offered to meet

the additional in-service training needs of professionals in the field. Training grants in mental retardation for fiscal year 1966 totaled $1,587,495. It is planned in fiscal year 1967 that $1,580,000 will be utilized in financial support for long-term training and traineeships in mental retardation.

Activities in fiscal year 1967 in the field of professional preparation will include:

Increase in numbers of students in graduate training programs in psychology, social work, rehabilitation counseling, physical therapy, speech pathology, and audiology receiving specialized training in rehabilitation of mental retardates through supervised field work in mental retardation settings, by means of support of instructional costs and traineeships.

Improvement in curriculum content and teaching methods in rehabilitation training projects through support of field teachers, development of case material and other teaching aids and encouragement of research in rehabilitation of the mentally retarded, and training courses dealing with the scope, nature and place of content on mental retardation in the curriculum. Included in the 1966 long-term grants was a grant to Parsons State Hospital and Training Center for the production of teaching films to be used in training rehabilitation personnel to serve mentally retarded persons. An institute on "Mental Retardation: A New Dimension in the Curriculum" is planned for representatives of all Schools of Social Work in the Spring of 1967.

Upgrading of personnel now serving the mentally retarded through short-term training courses of great variety in length, subject matter, intensity, depth and frequency. Included will be professional personnel in all relevant fields, sheltered workshop executives, floor supervisors and others in positions with management responsibilities.

Encouragement of a comprehensive, inter-disciplinary approach to the rehabilitation of mental retardates through training courses focused on inter-disciplinary program planning and operation of rehabilitation services.

Stimulation of training programs for assistant or aide positions in such fields as physical therapy, occupational theapy, social work and rehabilitation counseling, including definition of functions, definition of educational objectives, curriculum development and preparation of teaching materials.

Support of training programs for volunteers in rehabilitation of the mentally retarded, not only for assistance to professional presonnel engaged in services to individuals or groups, but also for lay leadership in community planning and program development.

Development of training programs to prepare executives and other management personnel in rehabilitation facility administration, including workshops offering sheltered employment, vocational evaluation or occupational adjustment services.

Extension and development of training in rehabilitative medicine to include orientation to mental retardation at the undergraduate level and at the residency level in physical medicine and rehabilitation.

Training grants in mental retardation based upon fiscal year 1966 obligations would include the following:

LONG-TERM TRAINING

Multi-Disciplinary Programs

California State College,
Los Angeles, California
University of North Carolina,
Chapel Hill, North Carolina
Columbia University,
New York, New York
Devereaux Foundation,
Devon, Pennsylvania
University of Wisconsin,
Madison, Wisconsin
New York Academy of Sciences,
New York, New York

FIELD INSTRUCTION UNITS

Rehabilitation Counseling

University of Florida,
Gainesville, Florida
Michigan State University,
East Lansing, Michigan
University of Oregon,
Eugene, Oregon
Southern Illinois University,
Carbondale, Illinois
State University of New York,
at Buffalo, New York
West Virginia University,
Morgantown, West Virginia
University of Wisconsin,
Madison, Wisconsin

Social Work

Boston College-Simmons College, Boston, Massachusetts
University of California, Los Angeles, California
University of Connecticut, Hartford, Connecticut
University of Denver, Denver, Colorado
University of Louisville, Louisville, Kentucky
University of Michigan, Ann Arbor, Michigan
New York University, New York, New York
University of Puerto Rico, Rio Piedras, Puerto Rico
Rutgers, The State University, New Brunswick, New Jersey
Syracuse University, Syracuse, New York
University of Texas, Austin, Texas
Tulane University, New Orleans, Louisiana
University of Utah, Salt Lake City, Utah
University of Washington, Seattle, Washington
University of Wisconsin, Madison, Wisconsin
University of Wisconsin-Milwaukee, Milwaukee, Wisconsin

Speech Pathology and Audiology

University of Georgia, Athens, Georgia
Michigan State University, East Lansing, Michigan

Physical Therapy

University of Oklahoma, Oklahoma City, Oklahoma

SHORT-TERM TRAINING

Catholic University of Puerto Rico, Ponce, Puerto Rico
Columbia University, New York, New York
Colorado State College, Greeley, Colorado
University of Georgia, Athens, Georgia
University of Illinois, Urbana, Illinois
University of Louisville, Louisville, Kentucky
University of Michigan, Ann Arbor, Michigan
University of North Carolina, Chapel Hill, North Carolina
Southern Illinois University, Carbondale, Illinois

One of the long-term training programs in the multi-disciplinary grouping, that at the University of Wisconsin, is now a Research and Training Center. The Research and Training Center program of the Vocational Rehabilitation Administration is covered in another section of this report, but it should be noted that Center training programs will continue to operate in the training area essentially as they formerly did. Long-term traineeships at these Centers will continue to be supported by Division of Training funds and, as previously noted, 8 such traineeships were awarded by the Research and Training Center at the University of Wisconsin in fiscal year 1966. Though the underlying content and intent of the multi-disciplinary courses are geared to vocational rehabilitation, the programs will serve many other professional disciplines either in their own professional grouping or in courses serving several professional disciplines.

The grant to the New York Academy of Science is for support of a series of two-day courses to train specialists in different fields in the concept and techniques of the interdisciplinary "workshop" conference. Such conferences are designed to provide an exchange of ideas and discussion in depth among scientists with different backgrounds and training but who have a common interest in an advancing front of knowledge. In this case the knowledge base focuses on mental retardation.

III. Research

The Division of Research Grants and Demonstrations administers a program of grants to States and to public and private, non-profit agencies to pay part of the cost for research, demonstrations, and the establishment of special facilities and services having the potential of contributing to the field of vocational rehabilitation. The Vocational Rehabilitation Administration sponsored projects would include: (1) Research projects which are intended to contribute new knowledge, principles, techniques, or devices to the field; (2) demonstration projects which apply the results derived from previous research or practice for

the purpose of developing and evaluating the effectiveness of new rehabilitation procedures; and (3) special facilities for vocational rehabilitation services to three or more States.

The major objectives of these several types of grants are: (1) the development of new information devices and methods to reduce the physical, psychological and social components of disability, and to evaluate, train and place in employment disabled persons; (2) the creation of new job opportunities demonstrating the ability and capacity of the disabled to work effectively in employment areas previously closed to them; (3) developing greater public understanding and increased community cooperation and financial support through demonstrations of what can be accomplished by new methods and knowledge; and (4) providing information to administrators and policy makers in State agencies, enabling them to broaden their perspective and apply new methods in the development of the State vocational rehabilitation program.

During fiscal year 1966 the Vocational Rehabilitation Administration supported a total of 74 projects with a prime focus in mental retardation. The total cost of these projects was $3,133,000. This reflects an increase in funds for mental retardation of approximately $43,000 in fiscal year 1966 as compared with 1965. The program for fiscal year 1967 will remain at about the same level of support which will be at $3,121,000.

Examples of the types of projects supported are as follows:

Demonstration of an Independent Living Rehabilitation Services Program for Seriously Handicapped Mentally Retarded Adults

The Occupational Success of the Retarded

Three Approaches to Group Counseling Involving Motion Pictures with Mentally Retarded Young Adults

Automation in Vocational Training of Mentally Ill and/or Retarded Adolescents

The Successful Retardate—Psychosocial Factors in Vocational Rehabilitation

A Program of Graduated Rehabilitation of Mentally Retarded Youth from Institutional to Community Living

A Structured Community Approach to Complete Services for the Retarded

Vocational Realism in Educable Mentally Retarded Adolescents

Comprehensive Community Based Services for the Retarded

Training Mental Retardates with Severe Defects for a Productive Occupation

The Relation of Certain Parental Attitudes and Expectations to the Progress of Retarded Children Served by A Regional Center

Coordinated Community Planning for Mentally Retarded

Factors Contributing to Successful and Non-Successful Community Adjustment of Discharged Retardates

Study of Differences Between Low Socio-Economic and Middle Class Retardates

Effects of Differential Daily Living Experiences on Retarded Persons Living in Residential Centers

Relationships Between Personality and Learning in the Retardate

Study of the Feasibility of an Inter-District Program for Trainable Retarded Adolescents

The program of research and demonstrations in the area of mental retardation includes both relatively basic studies of problems fundamental to the development of improved rehabilitation services and projects evaluating the effectiveness of new types of services.

Among the basic studies, for example, is an analysis of the effect of audio-visual feedback on social behavior of retarded adolescents. In this investigation retarded individuals observe and discuss their behavior as recorded on sound films.

Another area of emphasis is that of improved methods of training and induction of retardates in industry. For example, automated teaching methods have been developed for retardates both for purposes of prevocational training and for provisions of learning procedures on-the-job in factory situations. Training of supervisors of such workers also has been developed in connection with the latter project.

Four projects are ongoing in the area of comprehensive and coordinated community services to the retarded. These are located in Milwaukee, Wisconsin; Bridgeport, Connecticut; San Francisco, California; and Cleveland, Ohio.

A program especially devoted to problems of poverty is a New York study comparing lower and middle class retardates in workshop behavior, vocational success, etc; and attempting to develop and differentiate training and treatment suitable for the lower socioeconomic groups. This includes investigation of parental involvement and development of methods of increasing parental participation with workshop staff toward common, desirable rehabilitation objectives.

IV. Research and Training Centers

The Division of Research and Training Centers has expanded its programs to include the University of Oregon as well as the University of Wisconsin and the University of Texas. This new Research and Training Center in Mental Retardation was funded in March of 1966. This provides the Vocational Rehabilitation Administration with three Research and Trainng Centers in Mental Retardation; their total funds for fiscal year 1967 will be $750,000.

Historical Development and Purpose

Mental Retardation Centers were added to the Research and Training Center program in fiscal year 1965. These facilities for coordinated research and training provide training in mental retardation for professional and sub-professional personnel in the field who require orientation and additional preparation, and for students in any of the rehabilitation professions who desire to specialize in mental retardation. They provide assistance to State and local rehabilitation agencies in the planning and execution of in-service training programs in mental retardation. In the various teaching programs the results of current research are interpreted to bridge the gap between the knowledge available and its practical application. The research conducted at these Centers is programmatic investigation of critical problems associated with prevention and diagnosis of mental retardation, and with treatment, counseling, training and placement of mentally retarded youth and adults who can attain successful adaptation to life, socially, psychologically, and vocationally. In these Centers the services supplied to individuals are those necessary to the closely integrated research and training activities.

Impact on Problems of Mental Retardation

The two Centers operating in fiscal year 1966 have been in operation for about one year and nine months and have already provided training for more than 1,200 professional and sub-professional rehabilitation personnel from the medical areas, from various staff levels in vocational rehabilitation, workshop supervisors, special education teachers, social workers, psychologists, and volunteers. This was accomplished in many training courses. The number of participants is continually being increased in each new grant period. These programs are effectively training large numbers of workers at a time when the need for them is urgent. Short and long-term research is moving forward in critical areas such as the preparation of the adolescent retardate for a vocation: vocational and personality assessment to complement and supplement the training needed by the retardate; and the development of more effective methods for aiding retarded individuals toward maximal attainment of social adaptation, work adjustment, and ability to live in the community.

The University of Wisconsin is continuing its research upon subjects from a high-risk area that contains 2.5 percent of Milwaukee's total population, but includes 33 percent of the children enrolled in the public school program for the educable mentally retarded. Comparing high-risk families where the oldest child is retarded to low-risk families where the oldest child is not retarded, studies of the effects of "cultural-familial" retardation relative to work and community life; the effects of family stimulation on the incidence of socio-vocational failure among younger siblings in high-risk families, are continuing to develop. This should be one of the most definitive programmatic investigations into the socio-psychological factors in rehabilitation of the retarded.

In the longitudinal studies of adolescent retardates entering employment and independent community living, we anticipate new kowledge regarding work attitudes, predictors of vocational success in terms of behavioral, social, and emotional adaptation for planning rehabilitation for this group, and material on training techniques and behavioral therapy needed to improve the work potential of the adolescent retardate.

V. International Activities

The International Rehabilitation Research Program initiated by the Vocational Rehabilitation Administration in 1960 under authority of the Agricultural Trade Development and Assistance Act, is helping to support research projects on mental retardation in five countries: India, Israel, Pakistan, Poland, and UAR-Egypt.

The "Nandavan" Day School for the Mentally Retarded in Nagpur, India is developing and testing the effectiveness of vocational rehabilitation techniques and services in an educational and occupational training center for mentally retarded persons. At Malben-JDC in Tel Aviv, Israel, applied research on genetic and metabolic etiology of mental retardation is being integrated with a demonstration program for assessment of mentally retarded persons. A multi-disciplinary approach is being used by researchers at the Jinnah Post-Graduate Medical Center, Karachi, Pakistan, in order to determine the rehabilitation potential of the mentally retarded in Karachi to classify etiological patterns of mental retardation, and to develop a program of rehabilitation. In Warsaw, Poland, the Invalids' Cooperatives Union is developing and evaluating methods for training and placing the mentally retarded in employment in the Cooperatives and in other industrial work. The Department of Vocational Rehabilitation of the Ministry of Social Affairs Cairo, United Arab Republic, is conducting a study of the prevalence of mental retardation in youths, the rehabilitation potential of these persons, and the utilization of community resources, services and facilities to enable mentally retarded youths to achieve full rehabilitation.

In addition to these five projects, which focus directly on mental retardation, many of the one hundred other projects being supported by the Vocational Rehabilitation Administration in all of the participating countries have important implications for mentally retarded persons. For example, research findings on such matters as the causal, psychological, social and economic aspects of varoius types of disability can be applied to mental retardation, as can many of the techniques being developed through the projects for vocational evaluation, training and placement. For this reason, it is not uncommon for mentally retarded persons to be included among the study groups in many of the overseas research projects.

The Interchange of Experts Program, authorized by the International Health Research Act of 1960, is a means of pooling the knowledge and experience of rehabilitation workers in the United States with that of their overseas counterparts. This program brings overseas researchers associated with the projects to the United States for periods of two to three months to participate in and to observe rehabilitation research activities relating to their own. The program also sends American experts abroad for stipulated periods to work on the projects. During the five years since the program was initiated in the Vocational Rehabilitation Administration, more than one hundred overseas experts, including at least one person from each of the projects dealing directly with mental retardation, have been brought to the United States, and ninety American experts have been sent abroad. Many of these persons have participated in mental retardation research activities as part of their professional programs.

The Vocational Rehabilitation Administration plans to expand its international activities so that continuing and even greater benefits can be gained from progress other countries are making in the rehabilitation of the mentally retarded. The Vocational Rehabiiltation Administration will also continue to work toward the full utilization of the talents and capabilities of outstanding researchers in the fields of mental retardation and other rehabilitation specialties, both in the United States and overseas.

VI. Construction and Improvement of Rehabilitation Facilities and Workshops

The construction and improvement of rehabilitation facilities and workshops are of special importance in providing necessary services for the mentally retarded.

A. *Construction of Rehabilitation Facilities and Workshops.*—The Vocational Rehabilitation Act Amendments of 1965 authorized a comprehensive program incorporating Federal financial assistance beginning with State planning for rehabilitation facilities and workshops, carrying through individual project planning, and the construction of sheltered workshops. Special provisions are made for the mentally retarded to permit the inclusion of residential facilities.

The elements of this program are:

State Planning Grants for Workshops and Rehabilitation Facilities provide for coordination and orderly development of the total State-Federal facilities effort a five-year program of grants assistance with the costs of: (1) the development of a State Workshop and Rehabilitation Facilities Plan, and (2) a continuing program for assessing needs and evaluating activities for establishment, construction, utilization, development, and improvement of workshops and rehabilitation facilities.

In fiscal year 1966, 49 State Planning Grants were made, having a national average of $19,599.

Project Development Grants pay part of the cost of organized, identifiable activities attendant to the planning and development of specific local construction projects for rehabilitation facilities or workshops, oriented particularly towards assisting local citizens groups with limited financial resources to engage consultants and secure other types of help to develop a sound project proposal.

During fiscal year 1966, 13 Project Development Grants, having a national average of $7,300, were made to applicants planning a specific construction project providing services to the mentally retarded.

Construction Grants assist in the costs of the construction of new rehabilitation facilities and workshops and the expansion or alteration of existing ones, including initial equipment for the completed project.

Initial Staffing Grants assist in the costs of compensation of initial professional and technical staff for newly constructed workshops or rehabilitation facilities.

B. *Workshop Improvement Programs.*—The 1965 amendments, recognizing that many workshops are so inadequately staffed and poorly equipped that State vocational rehabilitation agencies cannot refer mentally retarded clients for services, authorized an extensive effort to upgrade workshops.

The elements of this program are:

Workshop Improvement Grants assist in the cost of analyzing, increasing, or improving those aspects of a workshop's operation which affect its capacity to provide employment and services for the handicapped. Approval projects may involve employment of additional staff, technical consultation, staff development activities, purchase or rental of equipment, and other activities. In addition, contracts may be made with State vocational rehabilitation agencies or with experts to provide technical assistance to workshops.

Fiscal year 1966 saw 40 Workshop Improvement Grants, having a national average of $24,000, made to applicants offering services to the mentally retarded.

Grants for Projects for Training Services assist in the cost of projects which provide training services leading to gainful employment to handicapped individuals in public or other nonprofit workshops and rehabilitation facilities. Federal financial participation may assist in the costs of such services as training in occupational skills, work evaluation, work testing, provision of occupational tools and equipment necessary for training purposes and job tryouts.

Welfare Administration

Children's Bureau

Introduction

The concern of the Children's Bureau for mentally retarded children and their families stems initially from its responsibility under the Basic Act of 1912 to "investigate and report on all matters pertaining to the welfare of children and child life." In the first 6 years of its existence, three of the major studies produced by the Bureau dealt with mental retardation.

The passage of the Social Security Act in 1935 and the assignment to the Bureau of the added responsibility of administering Federal grants for maternal and child health, crippled children, and child welfare services, emphasized the principle that all of the people, through the Federal Government, share with the State and local governments responsibility for helping to provide community services that children need to have for a good start in life. The Social Security Act also afforded the Bureau an opportunity to help the States develop demonstrations and special programs in areas where there were gaps in services.

As recently as 1954, maternal and child health activities in the Children's Bureau on behalf of mentally retarded children and their families were extremely limited. Many local public health nurses were reporting suspected mentally retarded children in their caseloads, but for the most part, they had few or no resources for establishing a diagnosis. By age groups, the greatest gap in available services was in relation to infants and preschool children. It appeared that many of the services that were lacking could best be provided through program emphasis within the framework of the maternal and child health program. The basic interests of this program—that is, preventive health services, child health supervision, growth and development and the fostering of good parent-child relationships—are also the basic interests of a program for mentally retarded children.

It was on this basis and to achieve these goals that the Congress, for fiscal year 1957, increased the Children's Bureau's annual maternal and child health appropriation and earmarked $1 million specifically for special projects serving this group of children. The Appropriations Committee also expressed the hope that an additional million dollars of the increase, which was to be distributed to the States on a regular formula basis, would be used to implement services for the mentally retarded. The enactment of P.L. 88–156 in 1963 increased the authorization and has resulted in increased appropriations both for special projects for mentally retarded children and in the amount of regular formula funds designated for this purpose. P.L. 89–97, "Social Security Amendments of 1965," made further improvements, including the provision of grants for the training of professional health personnel to work with crippled children, particularly the mentally retarded and those with multiple handicaps.

P.L. 89–97 also made available project grants to provide comprehensive health care and services for children and youth of preschool or school age, particularly in areas with concentration of low-income families. The authorization for the fiscal year 1966 for this program was $15 million, for fiscal year 1967, $35 million.

Mentally retarded children are also aided by the Children's Bureau's program of child welfare services whose objective is to assure that each child with this problem receives the care, protection, and services that can enable him to realize his full potential. Grant-in-aid child welfare funds authorized by the Social Security Act were used early in scattered instances in behalf of retarded children, for child welfare services, including foster care, and for child welfare workers who gave some service to this special group of children. In 1957, special child welfare staff was employed in the Federal program. The years since, as part of the Bureau's overall effort to reach out to special groups of children, have seen substantially increased child welfare services extended to the mentally retarded. Although programs for the mentally retarded have developed markedly, a considerable need for service to this group remains.

A further impetus to improving care to retarded children was provided by the Child Welfare Research and Demonstration Grants Program authorized by the Social Security Amendments of 1960 and by the Maternal and Child Health and Crippled Children's Services Research Projects authorized by the 1963 amendments. Some of the program research conducted under both of these programs pertains to mentally retarded children.

A. *Preventive Services.*—1. Maternity and Infant Care Projects: The report of the President's Panel on Mental Retardation emphasized the interrelationships of lack of prenatal care, prematurity, and mental retardation. A recent major emphasis in Children's Bureau programs has been the Maternity and Infant Care Projects, authorized by P.L. 88–156, "Maternal and Child Health and Mental Retardation Planning Amendments of 1963." This law provides for a new authorization for project grants to meet up to 75 percent of the cost of projects for the provision of necessary health care to prospective mothers who have or who are likely to have conditions associated with childbearing which increase the hazards to the health of the mothers or their infants and whom the State or local health department determines will not receive necessary health care because they are from low-income families or for other reasons beyond their control. In addition, the legislation provides for medical and hospital care for premature infants and other infants at risk. Late in fiscal year 1964, $5 million was appropriated for this program, and eight projects were approved. For fiscal year 1965, $15 million was appropriated, for fiscal year 1966, $30 million, and $30 million for fiscal year 1967. By the beginning of December 1966, 53 projects had been approved.

2. Phenylketonuria and Other Metabolic Diseases: A second major emphasis in prevention within the past few years has been in relation to phenylketonuria (PKU). This inborn error of metabolism has in the past been responsible for one percent of the population in our State institutions for the mentally retarded. By detecting families with the condition and by placing young infants with the condition on a special diet, mental retardation can usually be prevented. The Children's Bureau had been working with State health departments in developing and trying out various screening and detection programs, developing the necessary laboratory facilities, and assisting States in providing the special diet and follow-up programs for these families. When the Guthrie inhibition assay method for screening newborn babies was developed, the Children's Bureau supported field trials of this test. More than 400,000 newborn babies in 29 States were screened, and 39 cases of PKU were found, an incidence of almost one in 10,000.

The Children's Bureau is now urging that all States have a program for screening infants for PKU. Although such a program may be initiated without a legislative requirement, in many States laws have been enacted on this subject. As of the end of November 1966, 37 States had such laws, most of them making screening for PKU mandatory. The 37 States are:

Alabama
Alaska
California
Colorado
Connecticut
Florida
Georgia
Hawaii
Idaho
Illinois
Indiana
Iowa
Kansas
Kentucky
Louisiana
Maine
Maryland
Massachusetts
Michigan
Minnesota
Missouri
Montana
New Hampshire
New Jersey
New Mexico
New York
Oklahoma
Ohio
Oregon
Pennsylvania
Rhode Island
South Carolina
Texas
Utah
Virginia
West Virginia
Wisconsin

As more children with PKU are found, the problems relating to treatment services are receiving increased attention. Funds have been granted for planning a 5-year collaborative study of treated phenylketonuric children, for purposes of increasing knowledge of methods of treatment of children with this disease. A grant has also been made to develop a reference and standard service for phenylalanine determinations needed in screening and treatment. In April 1966, an important meeting was funded by the Children's Bureau to discuss PKU screening and treatment problems, pathogenesis of the disease, and other relevant topics. "Recommended Guidelines for PKU Programs" were prepared to make known the Children's Bureau recommendations for a comprehensive PKU program.

Interest is also increasing in metabolic diseases other than PKU that lead to mental retardation. The Children's Bureau is currently supporting a study of the clinical application of screening tests to detect galactosemia, maple syrup urine disease, and histidinemia. Also, support is being given to studies of new approaches to broader screening methods; for example, support is being given to a study which would make available a battery of automated tests for screening metabolic diseases. In addition, field trials are being conducted of a simple method to determine elevations of 10 different amino acids, for detection of metabolic disorders.

The concept of regional centers for treatment of PKU and other metabolic diseases has been developed, and during 1966, a grant for one such center was approved.

B. *Other Services.*—1. Clinical Services: Support of clinical services for mentally retarded children is one of the most important uses for Children's Bureau mental retardation funds. As of the end of November 1966, of the almost 200 mental retardation clinics in the country, the staff and services of 135 were sup-

ported in whole or in part by Children's Bureau funds. The Children's Bureau supported clinics served approximately 40,000 children in fisal year 1966. Somewhat over one-third of the children new to the program were under 5 years of age. The services provided include diagnosis, evaluation of a child's capacity for growth, the development of a treatment and management plan, interpretation of findings to parents and follow-up care and supervision.

The new Children and Youth Projects authorized by P.L. 89-97 offer an opportunity for providing increased services to mentally retarded children in the areas served by the projects. As of the beginning of December 1966, 25 Children and Youth Projects had been approved. These projects not only provide service, but, in accordance with the legislation, must include preventive services, which will have implications in the prevention of mental retardation.

2. Crippled Children's Services: Since enactment of the Social Security Act in 1935, the Federal Government, through the Children's Bureau, has assisted the States in providing services to crippled children. Although exact data are not available, it is known that relatively few mentally retarded children were cared for in these programs prior to 1963. The enactment of P.L. 88-156, providing for increased funds for the crippled children's program and for the earmarking of some of the funds specifically for mentally retarded children, has resulted in more attention being paid to physically handicapped retarded children. In some States, the definition of crippling conditions is being broadened to include conditions for which services had not hitherto been given. Some children who would formerly have been turned away are now being given service.

An important use of the expanded funds available for mentally retarded crippled children is in providing services for institutionalized children; for example, orthopedic services not hitherto available to these children.

Another use to which these funds are being put is the development of special clinic programs for multiply-handicapped children. Twelve such clinics were being financed by Children's Bureau funds as of July 1966.

3. Cytogenetic and Biochemical Laboratory Programs: A new use to which some of the Children's Bureau funds earmarked for mental retardation are being put is in the area of cytogenetic and biochemical laboratory services. Project grants have been approved which establish such programs as extensions of clinical services at hospitals or medical schools. Projects include chromosome analysis and diagnosis of various medical conditions which may be genetic and result in mental retardation. On the basis of these analyses, counseling may also be given to parents seeking advice on genetic questions. The biochemical laboratories may also do continuing monitoring of patients with metabolic diseases. Training in medical genetics is also an important aspect of many of these projects. By the end of November 1966, 17 such projects had been approved.

Indicative of the increasing interest in medical genetics, in March 1966 a group of experts in this field was called in to discuss and make recommendations on present and future Bureau programs in this area.

4. Child Welfare Services: The Children's Bureau administers child welfare services funds authorized in Title V, Part 3, of the Social Security Act as amended, for the purpose of cooperating with State public welfare agencies in establishing, extending and strengthening child welfare services. These funds are allocated to States on a formula basis. Child welfare services which can benefit the mentally retarded include parent counseling, homemaker services, day-care services, foster family care, small group care, services to unmarried mothers, protective services, and certain institutional preadmission and aftercare services.

At the present time, all State public welfare programs provide some social services for mentally retarded children. By conservative estimates of the Children's Bureau, 37,200 mentally retarded children receive services from public child welfare agencies. Over 5,500 are served by voluntary agencies.

Following are typical examples of State efforts to extend and improve services to the mentally retarded and their families:

Several States report that with the support of a child welfare worker and assistance provided through this service in utilizing other community resources, parents often are able to keep their retarded children at home and keep their families intact.

Homemaker services are being provided increasingly through State child welfare services programs for families of retarded children. A single county in one State provides homemaker services for several such families. In another

State, a homemaker has been employed by the State child welfare agency to provide services in a foster family home for retarded children. Still another State provides homemaker service through its child welfare program for a retarded mother of 9 children. Through homemaker service, an overburdened mother can be relieved of the constant and full responsibility of the day-to-day care of her retarded child. Frequently, she acquires new skills which help her in better home management and in her special problems with child care.

Several State public welfare agencies are developing day-care services for mentally retarded children. For example, one State is ready to open its 20th center for retarded and handicapped children and adults. The State family and children's agency which supervises the program now will provide up to 80 percent of the salary of fully qualified social workers employed by the centers. In another State, licensed day time activities centers have more than doubled in about a two-year period, from 21 to 43. The State child welfare agency licenses these centers. Day-care programs offer both constructive experiences for some retarded children and necessary relief for their parents. This sevice often may be the key factor in determining whether a child can remain with his family.

Most States provide some foster family care for retarded children. One of the less populous States estimates it has around 200 mentally retarded children receiving foster family care. In some school districts of another predominantly rural State, there are not enough retarded children of similar age and ability to establish a special class. For certain retarded children whose present primary need is an educational program, this State child welfare agency is cooperating with the educational agency to assure adequate foster family care in districts having special classes.

Some children who must be cared for outside their own homes can profit from close interpersonal relationships and respond to the stimulation of foster family life. Short-term foster care at intervals or during periods of crisis may enable a retarded child's family to provide adequately for him at home for the most part. For other retarded children, foster family care permits long-term benefits of family life and community living. Foster family care would be the plan of choice for many children who have been placed inappropriately in large residential facilities. In fact, some States are giving attention to the "exchange" of children between institutional and child welfare services programs to assure more appropriate services for particular children.

Child welfare services also may have preventive aspects in relation to mental retardation. For example, day care or foster care for children from certain deprived homes may be preventive services.

Homemaker service may be preventive in nature when brought into play with some expectant mothers who need relief from the physical demands of caring for other children. Protective services can reduce child abuse as a cause of mental retardation. Services to unmarried expectant mothers can assure utilization of proper prenatal services.

Child welfare workers also are in a key position with regard to early case-finding, assistance with obtaining proper diagnosis, and providing continuity of planning and services consistent with the individual retarded child's need.

In spite of the efforts an potential of child welfare services which have been cited, numbers of retarded children and their families need and could profit from child welfare services not now available. Professionally skilled staff, new programs, and extension of those in existence are needed. The growing emphasis on community services as a means of combating mental retardation will place increasing demands on child welfare agencies. Many States, however, have been unable to finance these special programs because of other pressing priorities which are also consistent with implementing the 1962 Public Welfare Amendments on use of State and Federal child welfare services funds.

5. Program Aids: The Children's Bureau has assisted in the production and circulation of films on mental retardation and has also operated an exchange of educational materials as a service to the mental retardation clinics. Since November of 1961, through this exchange, more than 350 items have been distributed to each of the mental retardation clinics in the country. Special publications have been developed which have been in great demand. In addition, pertinent articles appearing in various professional journals have been reprinted and distributed.

C. *Professional Preparation.*—1. Training for Health Services: Training activities for health services in the field of mental retardation, assisted by Children's Bureau funds, have encompassed many approaches: Grants for fellowships; support of and participation in institutes, conferences, and other short-

term training sessions; consultation on course curriculums; arrangements for clinical experience in mental retardation clinics; and distribution of informational materials to professonal workers.

The following points up the wide range of disciplines involved in training activities and illustrates the variety of training approaches. During fiscal year 1965, the Children's Bureau funded 27 pediatric fellowships in mental retardation; in fiscal year 1966, 39 such fellowships were funded. In nursing, assistance was given in fiscal year 1966 to 5 university schools of nursing to incorporate training in mental retardation into the maternal and child health curriculum; in addition, one university was given a grant for its program of continuing education of nurses in mental retardation. Assistance was also provided for short-term, intensive educational programs in mental retardation for practicing staff nurses, sponsored by State agencies. During 1966, 35 nutritionists attended a one-week workshop on nutritional services in mental retardation, sponsored by the Washington State Health Department, the University of Washington, and the Children's Bureau. The Children's Bureau also funded an Institute on Nutrition and the Inherited Diseases of Man held in May 1966 at the University of Minnesota Continuing Education Center.

In the 1966-67 academic year, 45 pre-masters social work students received their training in 19 Children's Bureau-supported mental retardation clinics from 20 graduate schools of social work; some of these students received stipends through training projects supported by the Children's Bureau. A small number of post-masters social work students, who are receiving stipends through Children's Bureau projects, received exposure to mental retardation in their field placements. Training of dentists to work with mentally retarded children was stimulated, as was the training of psychologists and speech and hearing specialists. During 1966, three symposia for professional physical therapists on the Child with Central Nervous System Deficit were supported by Children's Bureau funds at the University of Pennsylvania, Western Reserve, and Stanford Universities. A new development in 1966 was the imitiation of projects for the training of occupational therapists. Two special project grants were made, to the University of Florida and to Boston University's Sargent College, to enhance the professional education of occupational therapists to work with handicapped children. Also, two one-week seminars on perceptual-motor dysfunction were attended by nearly 500 occupational therapists involved in the evaluation and training of children with learning and motor disabilities.

Medical genetics represents a new field of training which was begun in fiscal year 1965 and extended in fiscal year 1966. Training programs, as part of the cytogenetic and biochemical laboratories, were set up for physicians and biochemists to specialize in aspects of medical genetics, particularly in cytogenetics, metabolic disease, and endocrinology.

The 1965 amendments to the Social Security Act made additional provision for grants for training purposes to be administered by the Children's Bureau. The amendments authorize appropriations for grants "for training professional personnel for health and related care of crippled children, particularly mentally retarded children and children with multiple handicaps." The amounts authorized for this purpose are $5 million for fiscal year 1967, $10 million for fiscal year 1968, and $17.5 million for each fiscal year thereafter. The new grants are to be made to public or other nonprofit institutions of higher learning, and will be a major source of support of personnel who will staff the university-affiliated centers for diagnosis and treatment of the mentally retarded, which are now being constructed.

2. Training for Child Welfare Services: States are urged to use Children's Bureau welfare services funds for tuition and maintenance grants for child welfare staff education leave. All States have structures for a staff development program including orientation, inservice training, and educational leave. These programs contribute to the overall increase of child welfare staff which is better able to serve the mentally retarded.

The 1962 Public Welfare Amendments provided a new avenue for augmenting the supply of trained child welfare workers by establishing grants for child welfare training projects. This program provides grants to public and other nonprofit institutions of higher learning for special projects for training personnel in the field of child welfare, including traineeships to students.

Training for child welfare services to the mentally retarded are included in this program. For example, five projects currently have approval under this

program for providing social work field instruction units in mental retardation settings.

While complete facts from schools of social work are not compiled on the current school year, during the 1965–1966 school year, 15 students receiving child welfare traineeships through this program were in mental retardation settings for their field instruction. For that year also, schools of social work reported that at least 27 child welfare-related mental retardation agencies were providing field experience for as many as 65 students.

A workshop for social work field instructors in mental retardation agencies and field instruction supervisors of schools of social work was also made possible through the child welfare training grants program.

D. *Research*—The Children's Bureau Clearinghouse, which maintains an inventory of current research relating to children, recently revised its 1960 publication, "Research Relating to Mentally Retarded Children," a listing of ongoing investigations in the United States.

Two research grant programs administered by the Children's Bureau can be used for program research assisting mentally retarded children:

1. Child Welfare Research and Demonstration Grants Program: The Child Welfare Research and Demonstration Grants Program, authorized by the Social Security Amendments of 1960, provides financial support for special research or demonstration projects in child welfare which are of regional or national significance, and for special demonstrations of new methods or facilities which show promise of substantial contribution to the advancement of child welfare.

Since community support is vital to improvement of child welfare services, an important function of several projects is to develop support through interpretation and communication of the problems that many children face, ranging from shattered families to mental retardation.

The projects relating to mental retardation include: (1) a demonstration to test the feasibility and value of foster home care for deprived mentally retarded children; (2) a demonstration, training, and service project designed to test the feasibility of training and using unskilled personnel as aides to professional personnel in caring for retarded children in the areas of homemaking and child care, physical medicine and nursing care, speech therapy, play activity, and auxiliary maternal care; (3) an evaluation of the quality of a family's decision to institutionalize or not to institutionalize a retarded child; and (4) a study of existing laws and their administration applicable to children suffering from mental disorders, including their commitment, care, and guardianship.

An area of continuing emphasis is development of effective programs for low-income families and children who are most vulnerable to adverse home and environmental influences which retard their growth and development. One such project is based on the parent training and day-care support to insure normal growth and development.

A grant was made to Howard University for a Project to determine how much a day-care program, plus parent education activities, can accomplish to offset intellectual and social disadvantages encountered by environmentally deprived children on entering public school. The research component of the Project was carried out by the Children's Bureau. Recently, the entire Project was transferred to George Washington University.

2. Maternal and Child Health and Crippled Children's Services: The purpose of this research grant program, authorized by the Maternal and Child Health and Mental Retardation Planning Amendments of 1963, is to support studies that show promise of making a substantial contribution to the advancement of health programs for mothers and children. Programs for mentally retarded children may be included in these studies.

In the area of mental retardation, projects have been funded which will study ways to improve amounts and quality of prental care. These are an effort to reduce the occurrence of prematurity and as a means of preventing mental retardation due to these causes. Several projects supported in various schools of medicine have as their objective an evaluation of methods for screening children for metabolic and other inherited diseases which can lead to mental retardation. They also seek to develop procedures for screening preschool children for neurological damage and psychological deviancy.

In one project, a major step may be achieved in alleviating the critical shortage of trained professional psychologists. This project will test, in selected mental retardation clinics throughout the country, a plan for utilizing nonprofessional personnel.

Another major study that has been funded proposes to uncover every case of mental retardation in a well-defined population. The prevalence of mental retardation and its relation to social, economic, and demographic characteristics of the individual and his household will be investigated in the hope of uncovering etiological relationships.

A study will be undertaken toward redirecting school nursing services in culturally deprived neighborhoods with a concentration on kindergarten pupils. This project will include: (1) routine home visits, (2) leading parent education study groups, and (3) providing more intensified followup of the mentally retarded and the neurologically handicapped.

BUREAU OF FAMILY SERVICES

Services under Public Assistance Programs

The Bureau of Family Services administers the public assistance titles of the Social Security Act. Under these laws, the Bureau is responsible for the six Federally-aided programs of public assistance: Old-Age Assistance, Medical Assistance for the Aged, Aid to Families with Dependent Children, Aid to the Blind, Aid to the Permanently and Totally Disabled, and the new Medical Assistance program under title XIX.

Three of these programs, assistance to the needy aged, the blind, and for dependent children, were established as part of the original Social Security Act in 1935, recognizing, that since the social insurance programs were neither complete nor adequate, public assistance was a necessary element of our social welfare program.

The Social Security Act of 1935 has been amended frequently, to include additional groups of people and to broaden its services. In 1950, a new title, X, assistance to the permanentely and totally disabled was added, and in 1965, title XIX, the Medical Assistance program was enacted. Title XIX not only supplements the Health Insurance program (Medicare) under title XVIII of the Social Security Act, but also includes certain groups of people not covered under title XVIII.

A basic service of public assistance programs is financial assistance, to enable families and individuals to purchase the necessities of life. Each State initiates and develops its own programs within the conditions of the Social Security Act; these conditions assure certain minimum standards. The freedom to determine the scope and content of their programs results in considerable variation between States in the level of assistance itself, as well as in the extent of other services. These levels reflect the State's fiscal capacity as well as its social philosophy.

Social Services

Until 1956, the public assistance titles made no specific mention of social services, although Federal policies encouraged the States to provide them. The 1956 Public Welfare Amendments recognized services as an important ingredient of public assistance and provided for Federal sharing in the costs of social services "to promote the well-being of the nation by encouraging the States to place greater emphasis on helping to strengthen family life and helping needy families and individuals attain the maximum economic and personal independence of which they are capable." The decision to provide services was left to States, however, and there was great variation among States, as well as within a State, in the services, if any, offered to assistance clients.

The 1962 Public Welfare Amendments were a giant step forward toward the ultimate goal of a comprehensive program of social services available to all citizens as a matter of right and regardless of financial status, as recommended by the Report of the Advisory Council on Public Welfare. When he signed them into law, President Kennedy said:

> "I have approved a bill which makes possible the most far-reaching revision of our public welfare program since it was enacted in 1935. This measure embodies a new approach, stressing services in addition to support, rehabilitation instead of relief, and training for useful work instead of prolonged dependency. This important legislation will assist our States and local public welfare agencies to redirect the incentives and services they offer to needy families and children and to aged and disabled people. Our objective is to prevent or reduce dependency and to encourage self-care and self-support—to maintain family life where it is adequate and to restore it where it is deficient."

The objectives of this legislation were clear: to encourage and support the States to provide minimum services through the inducement of increased Federal sharing in the costs; to assure attention to certain social problems that present grave threats to families, children and older persons or that offer the greatest potentiality for alleviation and prevention of personal and economic dependency; to enable public welfare to secure needed resources from other State programs; and to encourage services to potentially dependent adults and families at the earliest point.

Under these Amendments, 75 percent Federal matching is available for a wide range of services of particular value to the retarded. These include: parental counseling, consultation on legal, social, educational, medical, psychiatric and psychological problems. States can also provide specialized help to improve, restore or maintain clients' capacities for personal and social functioning such as homemaker services, family care for adults, group and volunteer services, social rehabilitation units, etc. In addition, States can elect to provide a comprehensive program of services to the retarded.

States have made considerable progress in implementing the 1962 Public Welfare Amendments. More than 10,000 social work positions have been added by State and local agencies. Caseloads have been reduced and training programs established. The emphasis on the importance of social services has also resulted in increased awareness of the needs of the retarded in public assistance caseloads and greater attention to meeting them.

State Welfare agencies provide a variety of services to retarded individuals and their families, including help in securing diagnosis and evaluation, preadmission studies, protective services for retarded adults in the community, supervision of children and adults leaving institutional care, etc.

State agencies are being encouraged to appoint State level consultants in mental retardation to develop a program of service to help the mentally retarded and their families cope with their problems and to plan staff development activities to increase understanding of these problems.

Medical Assistance—the New Title XIX Program

The new Medical Assistance Program is an extension of the program of Medical Assistance for the Aged which was authorized in 1960 by the Kerr-Mills amendments to the Social Security Act. When adopted by all States, it can provide comprehensive medical care to needy people. The title XIX program has a four-phase, step-by-step progression leading to a full range and scope of services.

First, top priority must be given to providing medical care for the public assistance groups—those receiving money payments in the categories of Old-Age Assistance, Aid to the Blind, Aid to the Permanently and Totally Disabled, and Aid to Families with Dependent Children. This is the minimum coverage that must be provided by the States if they have a plan under title XIX.

Second, title XIX allows States to provide assistance to groups of medically needy people who would qualify under the assistance categories if they were in sufficient financial need. When a State adopts a title XIX program, its Kerr-Mills program of Medical Assistance for the Aged goes out of existence. For the present, States have the option of including the medically needy—as contrasted with the public assitsance recipients described above—but if a State includes any of this group, it must include all the medically needy who are blind, disabled, or aged, or in families with dependent children. In other words, if a State pays for medical care for elderly people over age 65 who are self-supporting except for medical care, the State also must pay for medical care for medically needy blind and disabled persons, and for medically needy children and adults in families who would qualify for the basic assistance programs if their income met eligibility requirements.

A third phase in the implementation of title XIX is the so-called Ribicoff provision, which authorizes States, if they choose, to provide full and comprehensive medical care for *all* medically needy children under age 21, even if they cannot meet the eligibility requirements for AFDC. The parents can be employed full time but not earning enough to meet medical costs and still qualify for such aid for their children. Thus a family's income may cover all the children's basic daily needs; but if this family income is insufficient to meet the youngsters' medical needs, the children can be made eligible for the title XIX program.

And fourth, by July 1, 1975, substantially all of a State's medically needy must be included in a comprehensive program of medical care.

Thus, States can move ahead in four stages to ensure a broad spectrum of medical care for people who need it but cannot afford it. To summarize, this progression covers:

First of all, the 7.5 million people in the United States who depend upon the Federally-aided public assistance programs for all or some of their basic income.

Next, the people who are "categorically related"—whose incomes are above the level of eligibility for financial assistance for daily maintenance but who do need assistance with medical bills.

Then, all children under age 21 in any family with income insufficient to meet medical costs.

And finally, by 1975, any remaining medically needy persons.

An extremely important aspect in the new Medical Assistance Program is its timing. This factor gives States time to "tool up"—time in which to develop the programs for the high quality of medical care that is required under title XIX. States could begin to convert their existing programs to the new Medical Assistance Program any time after January 1, 1966. But by January 1, 1970, the conversion must be complete. After that date there will be no Federal sharing in the cost of medical care for public assistance recipients through a vendor payment system, except under title XIX.

Scope of Service

In regard to the scope of medical care to be provided, the law provides that States that set up a title XIX program between January 1, 1966, and July 1, 1967, must provide some institutional and some non-institutional care for all recipients. This is the same requirement that now applies to the Kerr-Mills program of Medical Assistance for the Aged. After July 1, 1967, however, any State operating under title XIX must provide, as a minimum, five services:

1. in-patient hospital services;
2. out-patient hospital services;
3. physicians' services (whether furnished in the office, the patient's home, a hospital, a nursing home, or elsewhere);
4. skilled nursing-home services for persons over age 21; and
5. laboratory and X-ray services.

The law specifically lists other items of medical service for which Federal sharing of costs will be available:

1. medical care, or any type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practices as defined by State law;
2. dental services, including dentures;
3. home health-care services, private-duty nursing services, clinic services, and physical therapy and related services;
4. prescribed drugs; prosthetic devices; and eyeglasses prescribed by a physician skilled in the diseases of the eye or by an optometrist, whichever the individual selects;
5. in-patient hospital or nursing home services for individuals 65 years of age and over in an institution for tuberculosis or mental diseases; and
6. any other type of remedial care recognized under State law and specified by the Secretary of Health, Education, and Welfare.

FOOD AND DRUG ADMINISTRATION

The Food and Drug Administration, responsible for the overall safety and efficacy of drugs, maintains a vigilant concern with the effects of drugs on infants and children. This preventative aspect of the Agency's statutory mission is exemplified by the work of the Investigational New Drug Branch of the Bureau of Medicine which emphasizes the importance of determining safety of drugs in women of childbearing age, and monitors the experimental use of new drugs in Phases I through III of their testing.

Unfortunately, few products are known to be efficacious in the treatment of mental retardation. The Food and Drug Administration has the authority and responsibility to initiate regulatory proceedings against drugs or devices represented to be useful in the prevention, treatment or amelioration of mental retardation which are not effective for such purposes. Furthermore, recommended dosages of drugs, food and supplements or food additives are being constantly re-evaluated in the light of new information. A recent Food and Drug Administra-

tion proposal, if adopted, will reduce the amount of vitamin D that may be added to food products. This action stemmed from a report relating the level of vitamin D intake in sensitive pregnant women to the induction of hypercalcemia, mental retardation and congenital heart disease in their offspring.

It is important for the Food and Drug Administration to keep abreast of research that indicates any untoward effect of chemicals used in foods, drugs, cosmetics, and household chemicals. To this end, close liaison has been established with the American Medical Association, the World Health Organization, and the pharmaceutical industry, in exchanging information concerning adverse reactions. The evaluation, cataloging and retrieval of this information, for ready consumer protection, is being undertaken by advanced data processing methods.

Social Security Administration

Purpose

The social security program today is established as the basic method in the United States of assuring income to individuals and families who suffer a loss of earnings when workers retire, become disabled or die and since July 1, 1966, health insurance protection to persons 65 and over.

Historical Development

As originally conceived in 1935, the social security program was to have provided only retirement benefits to aged workers. In 1939 benefits for dependents and survivors were added, and benefits became payable in 1940. Protection against long-term total disability was provided by the 1956 amendments and in 1965 disability was broadened and health insurance benefits for the aged added. Since 1949 there have been five general benefit increases, in recognition of the fact that prices and wages have gone up.

Economic Impact

The mentally retarded figure significantly among social security beneficiaries, particularly among dependents who have been continuously disabled since childhood. The problem of mental deficiency is a major factor in more than 65 percent of the beneficiary group having disabilities which began in childhood. It is the primary diagnosis in about half of all childhood disability cases. In fiscal year 1966 an estimated 134,000 adult mentally retarded beneficiaries received $84,500,000 in social security benefits. The number of mentally retarded children under age 18 who receive payments as dependents of retired, disabled, or deceased workers is unknown. The known mentally retarded beneficiaries range in age from 18 to over 65 with at least half being over 35.

The social security law has special importance for the parent of a mentally retarded child because it can provide a source of assured income where the parent is entitled to social security retirement or disability insurance benefits, or the parent was insured at the time of death. If the parents are dead, a relative who has demonstrated a continuing interest in the beneficiary's welfare, a welfare agency or a legal guardian may be chosen as representative payee to handle the benefit funds and plan for using them in behalf of the beneficiary.

A representative payee receives social security benefits in trust for the beneficiary and, as a trustee, is held accountable for the way in which he uses the benefits.

Activities and Achievements

All district offices of the Social Security Administration maintain a referral service to other programs and services of both public and private agencies and organizations. Giving information about these programs and agencies is an essential part of the Social Security Administration's service to the public. Disabled persons applying for disability benefits under social security are promptly referred to the Office of Vocational Rehabilitation to the end that the maximum number may be rehabilitated into productive activity or to a level of self-care. Information and referral service is also provided to non-beneficiaries or applicants who inquire about services at social security district offices.

The Social Security Administration has participated in the program for employment of the mentally retarded since its inception. A total of 30 are on duty at the present time as follows: 17 in Baltimore Headquarters offices, one in the District of Columbia, 8 in payment centers and 4 in district offices. These employees perform routine, repetitious clerical duties such as duplicating machine operation, stapling, envelope stuffing, mail opening, and numerical and alpha-

betical breakdown of material to be filed. All are performing in a highly satisfactory manner and 5 have done well enough to be promoted to GS–2.

In the area of public information the Social Security Administration developed and gave wide distribution to a pamphlet entitled "Social Security: What it Means for the Parents of a Mentally Retarded Child." The pamphlet was recently revised to encompass provisions of the 1965 Social Security Amendments.

The Social Security Administration is developing a program-oriented exhibit on the theme of childhood disability with emphasis on mental retardation. The exhibit will have its first showing at the annual meeting of the American Orthopsychiatric Association in March 1967. Thereafter it will be available without charge for showing to other interested groups on request to the Professional Relations Staff of the Bureau of Disability Insurance, Social Security Administration, Baltimore, Maryland, 21235.

Also in the planning stage is a film on what social security means to the mentally retarded child and his family. The film would be one of a series being produced in color for television, featuring social security beneficiaries whose "stories" have dramatic human interest appeal. The mental retardation film would portray a "day in the life of" a mentally retarded child beneficiary and his family.

The Social Security Administration is preparing for a nationwide survey which will supply basic information about institutionalized adults, including the mentally retarded in institutional care. The 1967 survey of institutionalized adults will examine the socio-economic characteristics of mentally retarded persons (as well as other disabled persons) over age 18 in institutions such as homes and schools for the mentally or physically handicapped, mental hospitals, chronic diseases and other long-term hospitals. This survey will focus on the types of care they receive, the cost of care and sources of payment, the economic resources of the patient and his family, and his family relationships.

One aspect of particular interest to the Social Security Administration is the status of incompetent beneficiaries with representative payees. The representative payee relationship of the patient will be determined from social security records and from the institutional interview data. The data collected in this survey will assist in the evaluation of the program policy and procedures for representative payees.

The 1966 survey of disabled adults (non-institutionalized) will also provide a wide range of data on financial, medical and family arrangements of disabled adults who are mentally retarded.

Administration on Aging

A new program of importance to 3,000 mentally retarded children as well as many other children is now well underway. The Foster Grandparent Program is designed to employ impoverished elderly Americans in a service role with institutionalized children up to 16 years of age who may benefit from a relationship with a concerned and mature adult. The impoverished elderly who become foster grandparents work four hours a day and receive remuneration for their work. In turn, they provide additional attention and opportunities, within an atmosphere of "tender, loving care," to the childen they serve.

The Department of Health, Education, and Welfare through the Administration on Aging, and the Office of Economic Opportunity, share the responsibility for the Foster Grandparent Program. The Office of Economic Opportunity provides the funds and retains general evaluation and fiscal responsibilities. The Administration on Aging has responsibility for the development, supervision, consultation, and general management of the Foster Grandparent Program projects. Both agencies cooperate in generating local interest and action for Foster Grandparent Program projects.

At the present time there are 41 authorized projects in the United States which employ 2,900 foster grandparents to serve all types of institutionalized children. Well over half of the program is directed to serve the mentally retarded children in 37 institutions.

The core of the foster grandparent program is the provision of tender, loving care, two hours per day, to individual children under age 16. This service must be in addition to the existing agency program. The program is intended to provide an added dimension to agency services. Foster grandparents do not serve merely as extra hands to relieve existing staff of routine duties. No

maintenance or custodial responsibilities are assigned to foster grandparents; however, activities such as feeding, changing diapers, attending to specific child-related problems in the institutional environment that are a natural part of giving attention to an assigned child are permitted.

By fulfilling this role, foster grandparents have helped children who were considered non-ambulatory learn to walk. Others who were unable to talk have learned to talk. Many children have learned to feed and dress themselves. Institutions have reported that the warmth and zeal brought about by the foster grandparents have re-inspired institutional staff to improve the help they give to the children.

Surplus Property Program

The Division of Surplus Property Utilization, within the Office of the Assistant Secretary for Administration, carries out the responsibilities of the Department under the Federal Property and Administrative Services Act of 1949, which makes available for health and educational purposes surplus Federal real and personal properties. The properties which become available under this program are those that have been determined by the General Services Administration as no longer having any further Federal utilization.

Surplus personal properties are screened to determine those types which may be needed and usable by eligible institutions throughout the country in conducting health and educational programs. Properties determined to have utilization for these purposes are allocated by the Department of Health, Education, and Welfare for transfer to State Agencies for Surplus Property which have been established in all States. It is the function of these State Agencies to secure the properties, warehouse them, and make them available to eligible donees for health and educational uses. The only cost to the eligible donees are the handling and service charges which are assessed by the State Agencies.

In the case of real properties which have been determined to be surplus to Federal needs, notices of their availability are sent to potential eligible applicants either by the State Agencies or the Regional Representative for Surplus Property located in each of our nine Regional Offices. Real properties available for removal from their site for relocation are conveyed by agreement of sale with restrictions as to the use of the facilities which run for a period of 5 years. These properties are conveyed with a 95 percent public benefit allowance discount from their fair market value. Land or land and buildings together with other improvements are conveyed by deed which contain restrictions as to use for a period of 30 years. These properties are conveyed with public benefit discount allowances ranging from 50 to 100 percent of fair market value. The only other costs to eligible transferees are "out of pocket" Federal cost, i.e., appraisals, surveys, etc.

Schools for the mentally retarded are eligible to acquire surplus real and personal property. In the case of personal property, such a school must be operated primarily to provide specialized instruction to students of limited mental capacity. It must be tax-supported or non-profit and exempt from taxation under Section 501(c)(3) of the Internal Revenue Code of 1954. It must operate on a full-time basis with a staff of qualified instructors for the equivalent of a minimum school year prescribed for public school instruction of the mentally retarded. It must also demonstrate that the facility meets the health and safety standards of the local governmental body. In the case of real property, the applicant must be a State or political subdivision thereof, or instrumentality, a tax-supported educational or public health institution, or a non-profit educational or public health institution that has been held to be exempt from taxation under Section 501(c)(3) of the Internal Revenue Code of 1954. Its proposed program of use must be for a fundamentally educational or public health purpose; i.e., devoted to academic, vocational or professional instruction, or organized and operated to promote and protect the public health.

Types of personal property available would range anywhere from a nail to an electronic computer. Many items of surplus personal property have never been used before. Real properties would consist of all types of buildings which are removable, land with or without structures, and other improvements such as utility lines, sewer and water systems, etc.

Pamphlets giving more detailed information as to eligibility of organizations for both surplus real and personal properties, as well as additional information in connection with the surplus property utilization program, along with a directory of the State Agencies for Surplus Property and the nine regional offices of

the Department, may be obtained from the Division of Surplus Property Utilization, U.S. Department of Health, Education, and Welfare, Washington, D.C., 20201.

The following are examples of real properties conveyed under the program for use in aiding the mentally retarded. Frequently, these facilities are put to a joint use, namely, for the training of the mentally retarded as well as the physically handicapped. Other conveyances have been made for hospital use where, as a part of the total program, portions of the facility are used for the treatment and training of the mentally retarded.

The State of Missouri passed legislation authorizing the State Department of Education to establish and operate State schools for mentally retarded in any County or in a District comprised of two or more Counties. One of the first of these schools has been established on the 4.95 acres of land and 9 buildings we conveyed for this purpose at the surplus O'Reilly General Hospital, Springfield, Missouri. The facility is a day school for a maximum enrollment of 90 children.

The State of Florida has undertaken the establishment of a System of Sunland Training Centers throughout the State for the training of its mentally retarded children. Present plans call for 10 of these Centers having capacity of approximately 1,000 resident students each. One of these Centers, serving the northwest section of the State, has been established at Marianna, Florida, on 372.67 acres of land and 65 buildings, formerly the Graham Air Force Station through our surplus property utilization program. Most of the pesonal property for the operation of this facility was conveyed with the real estate.

Other States also have programs for the mentally retarded, using Federal surplus real property. The Department conveyed 34.39 acres of land and 47 buildings, formerly the Lufkin Air Force Base, Lufkin, Texas, to the Texas State Hospital and Special Schools for a resident unit to accommodate between 1,000 and 1,500 retarded children. Louisiana received 537 acres with modest improvements at the Belle Chasse Navy Ammunition Depot, New Orleans, as a site for a State unit serving this area for day treatment and resident training and care of mentally retarded. The State of Kansas has renovated the Winters Veterans Administration Hospital, also an intact transfer comprising 225 acres and 195 buildings, for the treatment and care of some 300–400 mentally retarded children.

The Warren City School District, Warren, Ohio, has initiated a novel program for learning incentive for slow learning pupils of intelligence quotients between 50 and 79. Through our program, the School District obtained 76.4 acres of land and 10 buildings from the Youngstown Family Housing Annex, Trumbull County, Ohio. There are farm ponds, vocational shops, and programs for conservation and horticulture. An experiment in providing summer garden plots for these pupils was significantly successful.

The State of Georgia obtained the former Veterans Administration Domiciliary in Thomasville, consisting of 207 acres of land and 131 buildings, with a bed capacity of 400 to 800, for the care and rehabilitation of the mentally ill and retarded. Another site of nearly 200 acres at the former U.S. Penitentiary Honor Farm near Atlanta has been conveyed for a Regional Mental Hospital for the rehabilitation and training of the mentally ill and retarded. The State of Ohio received the former Veterans Administration Hospital at Broadview Heights, near Columbus, which will initially accommodate 250 mentally retarded, with a future capacity of 600. This will greatly alleviate the critical situation in this area where, in this one county alone, there is a waiting list of 2,200 mentally retarded requiring treatment.

Smaller areas, such as former Post Office buildings and sites, Nike Sites, have been converted into schools and training centers. The former Post Office at Carlisle, Pennsylvania, is now a school, operated by the Cumberland County Association for Retarded Children; Lake County, Ohio, has converted the former Post Office at Willoughby into a school for the retarded; and portions of Nike Sites at Needham, Massachusetts, and King County, Washington, are now used in the care and training of the mentally retarded.

These are but a few examples of where Federal property, both large and small, which are no longer required for Government use, are serving the country in the care of its mentally retarded.

Through June 30, 1966, 4,510 acres and 662 buildings have been transferred to institutions for use in programs serving the mentally retarded. These properties originally cost the Government $30,265,643, and had a fair market value of $9,470,734 at time of transfer.

APPENDIX A

Department of Health, Education, and Welfare Obligations for Mental Retardation Programs, Fiscal Years 1966–1967

Obligations for programs on mental retardation

Agency and appropriation	1956	1964	1965	1966	1967 estimate	1968 estimate
Office of Education:						
Elementary and secondary education activities	0	0	0	[1] $20,962,742	$26,725,000	$34,750,000
Educational improvement for the handicapped	0	$6,753,364	$7,234,956	8,976,636	10,380,000	[2] 11,548,000
Research and training	0	422,447	566,461	254,960	91,546	26,804
Total, Office of Education	0	7,175,811	7,801,417	30,194,338	37,196,546	46,324,804
Vocational Rehabilitation Administration:						
Grants to states	375,000	5,500,000	7,500,000	13,764,150	23,104,000	31,080,000
Research and demonstration projects	99,000	2,278,000	3,090,000	3,133,000	3,005,000	2,953,000
Training and traineeships	0	878,000	1,213,000	1,501,000	1,870,000	1,950,000
Special rehabilitation research and training centers	0	0	385,000	500,000	750,000	1,050,000
Innovation grants	0	0	0	225,000	300,000	300,000
Expansion grants	0	0	0	86,500	200,000	300,000
Research and training (special foreign currency program)	0	175,000	93,000	80,000	408,000	----------
Total, Vocational Rehabilitation Administration	474,000	8,840,000	12,281,000	19,289,650	29,637,000	37,633,000
Public Health Service:						
Community health services	0	2,011,000	9,712,000	28,811,000	43,485,000	42,420,000
Exclusively mental retardation	0	0	(9,712,000)	(28,811,000)	(43,485,000)	(42,420,000)
National Institute of Neurological Diseases and Blindness	919,000	20,376,000	22,636,000	23,808,000	23,861,000	24,867,000
National Institute of Child Health and Human Development	0	5,991,000	7,279,000	8,500,000	12,078,000	20,628,000
Exclusively mental retardation	0	0	(3,642,000)	(5,368,000)	(7,788,000)	(8,496,000)
Grants for construction of health research facilities	0	0	14,745,000	6,234,000	6,026,000	0
Exclusively mental retardation	0	0	(13,740,000)	(6,234,000)	(6,025,000)	0
Mental health research and services	923,000	7,303,000	11,466,000	15,334,000	6,379,000	6,670,000
Exclusively mental retardation	0	0	(8,325,000)	(2,522,000)	(2,528,000)	(4,900,000)
National Health Statistics	0	10,000	11,000	21,000	21,000	21,000
Total, Public Health Service	1,842,000	35,691,000	65,849,000	82,708,000	91,850,000	94,606,000
Total, exclusively mental retardation	0	0	(35,419,000)	(42,935,000)	(59,826,800)	(55,816,000)

Welfare Administration:						
Bureau of Family Services: [3]						
Grants to States for public assistance	12,000,000	38,000,000	44,000,000	51,000,000	[4] 53,000,000	57,000,000
Salaries and expenses	7,000	25,000	44,000	55,000	65,000	75,000
Children's Bureau:						
Grants for maternal and child welfare	88,000	12,858,000	23,029,000	49,600,000	54,885,000	78,805,000
Salaries and expenses	3,000	330,000	737,000	1,030,000	969,000	1,025,000
Total, Welfare Administration	12,098,000	51,213,000	67,810,000	101,685,000	108,919,000	116,905,000
Social Security Administration:						
Estimated benefits payments from the trust funds	0	(63,700,000)	(70,900,000)	(84,500,000)	(88,400,000)	(96,200,000)
Trust fund obligations incurred to adjudicate claims of beneficiaries	0	(1,600,000)	(1,900,000)	(1,800,000)	(2,100,000)	(2,100,000)
Total, Social Security Administration	0	(65,300,000)	(72,800,000)	(86,300,000)	(90,500,000)	(98,300,000)
Office of the Secretary:						
Office of General Counsel (legal services)	0	22,000	42,000	42,000	44,000	46,000
Intradepartmental coordination [5]	0	(39,000)	(198,000)	(238,000)	(105,000)	(105,000)
President's Committee on Mental Retardation	0	0	0	0	[5] (158,000)	[6] 597,000
Grand total, general funds	14,414,000	102,941,811	153,783,417	233,918,988	267,646,546	296,111,804
Grand total, trust funds	0	65,300,000	72,800,000	86,300,000	90,500,000	98,300,000
Grand total, all funds	14,414,000	168,241,811	226,583,417	320,218,988	358,146,546	394,411,804

[1] Estimated.

[2] Not including funds authorized under title VI of Public Law 89-10 as amended by Public Law 89-750.

[3] Exact information is not available on the costs due to mentally retarded people who are receiving public assistance because data secured does not single out this one cause as a factor of disability or dependency. However, it is known that mental retardation is an important cause of disability for those receiving aid to the permanently and totally disabled under the Federal-State public assistance program. The amounts shown here are estimates based on a constant percentage of total payments under this part of the program.

[4] Includes funds from proposed supplemental for public assistance grants for 1967.

[5] Shown as nonadd items since they were derived from funds available to other agencies for mental retardation activities.

[6] Beginning in 1968, this item is included in direct funding as a part of the account "Mental health research and services."

APPENDIX B

AUTHORIZATIONS FOR APPROPRIATIONS FOR MENTAL RETARDATION GRANTS, 1964–69

P.L. 88–156, "Maternal and Child Health and Mental Retardation Planning Amendments of 1963"
P.L. 88–164, "Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963"
P.L. 89–97, "Social Security Amendments of 1965"
P.L. 89–105, "Mental Retardation Facilities and Community Mental Health Centers Construction Act Amendments of 1965"

[Millions of dollars]

	Fiscal years						
	1964	1965	1966	1967	1968	1969	Total
Public Law 88–156:							
Extending authorization:							
Maternal and child health services	5.0	10.0	15.0	15.0	20.0	[1] 20.0	85.0
Crippled children's services	5.0	10.0	15.0	15.0	20.0	[1] 20.0	85.0
New Legislation:							
Special project grants or maternity and infant care	5.0	15.0	30.0	30.0	30.0	.....	110.0
Reaearch projects relating to maternal and child health and crippled children's services	2.0	3.0	4.0	6.0	8.0	[2] 8.0	31.0
Grants for planning comprehensive action to combat mental retardation	2.2	.....	.....	.....	.....	.....	2.2
Total, Public Law 88–156	19.2	38.0	64.0	66.0	78.0	48.0	313.2
Public Law 88–164 (as amended by Public Law 89–105):							
Mental retardation construction	11.0	25.5	28.5	31.0	30.0	.....	126.0
Research centers	6.0	8.0	6.0	6.0	.....	.....	26.0
Facilities:							
University grants	5.0	7.5	10.0	10.0	.....	.....	32.5
State grants	.....	10.0	12.5	15.0	30.0	.....	67.5
Education of the handicapped	15.0	16.5	25.5	38.5	46.0	51.5	193.0
Training grants	13.0	14.5	19.5	29.5	34.0	37.5	148.0
Research and demonstrations	2.0	2.0	6.0	9.0	12.0	14.0	35.0
Total, Public Law 88–164	26.0	42.0	54.0	69.5	76.0	51.5	319.0
Public Law 89–97:							
Training of professional personnel	.....	.....	.....	5.0	10.0	17.5	32.5
Implementation of mental retardation planning	.....	.....	2.75	2.75	.....	.....	5.5
Total, Public Law 89–97	.....	.....	2.75	7.75	10.0	17.5	38.0

[1] Public Law 88–156 authorizes an increase of $25,000,000 or fiscal year 1970, "and succeeding fiscal years."
[2] Public Law 88–156 authorizes $8,000,000 "for any fiscal year."

APPENDIX C

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE—REGIONAL OFFICES

Regional Directors

Region I

Walter W. Mode, John Fitzgerald Kennedy Federal Building, Boston, Massachusetts 02203 (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont)---------- 223–3550

Region II

Bernice L. Bernstein, 42 Broadway (Room 1200), New York, N.Y. 10004 (Delaware, New Jersey, New York, Pennsylvania)------ 264–4600

Region III

Bernard V. McCusty, 220 7th Street, Charlottesville, Virginia 22901 (District of Columbia, Kentucky, Maryland, North Carolina, Virginia, West Virginia, Puerto Rico, Virgin Islands)---------- 296–1220

Region IV

William J. Page, Jr., Peachtree-7th Building, 50 7th Street, N.E. (Room 104), Atlanta, Georgia 30323 (Alabama, Florida, Georgia, Mississippi, South Carolina, Tennessee)---------- 526–5817

Region V

Melville H. Hosch, New Post Office Building (Room 712), 433 W. Van Buren Street, Chicago, Illinois 60607 (Illinois, Indiana, Michigan, Ohio, Wisconsin) ---------- 828–5160

Region VI

James W. Doarn, Federal Office Building, 601 East 12th Street, Kansas City, Missouri 64106 (Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, South Dakota)---------- 374–3436

Region VII

James H. Bond, 1114 Commerce Street, Dallas, Texas 75202 (Arkansas, Louisiana, New Mexico, Oklahoma, Texas)---------- 749–3396

Region VIII

William T. VanOrman, Federal Office Building (Room 9017), 19th & Stout Street, Denver, Colorado 80202 (Colorado, Idaho, Montana, Utah, Wyoming) ---------- 297–3373

Region IX

Charles H. Shreve, Federal Office Building, 50 Fulton Street, San Francisco, California 94102 (Alaska, Arizona, California, Hawaii, Nevada, Oregon, Washington, Guam, American Samoa)---------- 556–6746

APPENDIX D

REFERENCES

Mental Retardation Grants, F.Y. 1966.—Available from the Superintendent of Documents, Washington, D.C., 20402—Price 70 cents.

This publication lists the grants awarded in the field of mental retardation by the operating agencies of the Department of Health, Education, and Welfare from July 1, 1965–June 30, 1966. The grants are arranged by State since it is designed primarily for use by State groups involved in planning for comprehensive action to combat mental retardation. A subject index of the research and demonstration grants is included.

Mental Retardation Report.—Available without charge from the Secretary's Committee on Mental Retardation, U.S. Department of Health, Education, and Welfare, Washington, D.C., 20201.

A newsletter issued by the Secretary's Committee on Mental Retardation; describes current program developments in the field of mental retardation.

The Problem of Mental Retardation.—Available from the Superintendent of Documents, Washington, D.C., 20402—Price 15 cents.

This booklet is designed as a basic introduction to mental retardation and an overview of the problems related to it. Mental retardation is defined, ways in which the patient can be helped are given, and the causes and the future of the problem are discussed.

Financial Assistance Programs in Mental Retardation of the Department of Health, Education, and Welfare.—Available from the Superintendent of Documents, Washington, D.C., 20402—Price 25 cents.

Summarized in this publication are those financial assistance programs in mental retardation that are administered by the Department of Health, Education, and Welfare, and currently available under existing authority. In most instances, these programs are grants-in-aid to State and local groups for the support of mental retardation activities.

Mental Retardation Publications of the Department of Health, Education, and Welfare.—Available without charge from the Secretary's Committee on Mental Retardation, U.S. Department of Health, Education, and Welfare, Washington, D.C., 20201.

Annotated listing of all mental retardation publications issued by the Department of Health, Education, and Welfare. Includes a subject index.

Activities in Aging

The activities in aging undertaken by the Department of Health, Education, and Welfare in 1966 were directed primarily toward implementing the several new programs for older people authorized by the Congress in 1965.

The impact of the new legislation upon older people, together with improvements in the programs for the elderly already administered by the Department, is reflected in part by the increase in the value of benefits and services to the aged between 1965 and 1966 throughout the Federal Government. In 1965, Federal expenditures for persons aged 65 and over totaled some $18.7 billion. This amount rose to an estimated $21.2 billion in fiscal year 1966, or an increase of some 13.6 percent in the value of benefits and services. About 98 percent of the value of these benefits and services went to older people in the form of direct cash payments to retirees, the disabled, survivors, some unemployed, and to public assistance recipients. The $21.2 figure is for all Federal programs in aging.

This report documents that effective action on behalf of older people involves many activities of the Department of Health, Education, and Welfare: health insurance, manpower training, education, income security, health and other facilities, and activities to outlets for a more meaningful life. Working with the States and nongovernmental agencies, the Department of Health, Education,

and Welfare is seeking to strengthen and stimulate all available resources in a concerted effort to find solutions to the problems and needs of older people. The following is a report of the Department's activities in 1966 on behalf of older people:

Administration on Aging

The year 1966 marked the first full year of operation for the Administration on Aging, the newest operating agency of the Department of Health, Education, and Welfare. Created by the Older Americans Act of 1965, the Administration serves as the central focus within the Federal Government in all areas of interest to the Nation's older people. The Administration serves as a traffic center of ideas for improving the lives of the elderly and acts as a clearinghouse of information pertaining to aging and the aged in the United States. Among the most important functions assigned to the Administration on Aging is the stimulation of the effective use of the resources and programs for the aged throughout the country. The Administration carries out this function by working directly with other Federal agencies to assure closer coordination of the programs which affect the lives of older people. The Administration also operates three grant programs to encourage the development of aging programs in States and communities, to conduct research into the techniques for improving services for older people and to demonstrate these techniques in pilot projects, and to train professional and other personnel in the field of aging.

Grants for community planning, services, and training

Title III of the Older Americans Act provides for allotment of funds to strengthen State services to the aging and to enable States to make grants to communities and nonprofit private organizations serving older persons. Funds made available under the title III program can be used in community planning, services, and training.

Before the Older Americans Act, States reported two major problems which inhibited the development of programs for their older citizens: (1) the lack of sufficient resources to initiate needed services and activities on behalf of older people, and (2) the absence of permanent or effective agencies on aging at the State and community level to effectively plan and implement programs for the elderly. Since the passage of the Older Americans Act, 51 States and Territories have designed agencies who are solely responsible for developing programs which will improve the lives of their older residents. The primary responsibility of these agencies is to develop and administer a comprehensive plan designed to meet the needs of older people in the State. The focus of each plan is to develop services in the communities and neighborhoods where older people actually live.

State plans which are designed to carry out the purposes of the Older Americans Act have been approved and programs are now operational in 43 States and Territories. The plans of 5 additional States are under development and are expected to be submitted for approval during fiscal year 1967.

Early in the development of the title III program, designated agencies on aging were asked to identify the major unmet needs of the older people living in their States. The problem cited most frequently was the lack of effective planning and organization for the provision of services to the aged at the local level. Another significant problem was the absence of centrally located programs available to a large percentage of the aged in the community, such as those provided by multipurpose senior activity centers. Other problems often mentioned by the State agencies included the need for more trained personnel, the lack of good information and counseling or referral services, and the absence of other community social services important to the lives of the elderly in the community.

States with operational title III programs have already budgeted the total amount of the Federal allotment funds available to them for fiscal years 1966 and 1967. The manner in which these have been budgeted parallels the needs

identified by the State agencies during the tooling-up phase of the title III program:

Program area and percent of total amount budgeted

Community planning, development, and coordination	24
Multipurpose senior activity centers	33
Counseling and referral services	7
Housing	1
Training of special personnel	6
Employment	5
Recreation	6
Services in the home	7
Health	5
Senior citizen education	2
Senior volunteer programs	4
Total	100

One of every four dollars was budgeted for community planning and development programs. Such programs attempt to organize local committees on aging and plan for and provide opportunities and services for the older person in the community. One of every three dollars was budgeted by the States for the establishment and operation of multipurpose senior activity centers. Senior centers, for example, are one of the most effective ways to provide services for older people and to provide an atmosphere in which the older individual can continue to make contributions to community life through the activities sponsored by the center. Center programs often become a base from which other aging programs are developed on a community-wide basis. Where possible older people themselves provide these services or assistance to other elderly residents. The remaining amounts allotted to the States was budgeted for a variety of programs, dependent for the most part on the individual needs of older people in a particular community.

Most title III projects offer a variety of services for the older person. The average senior center, for example, usually provides five distinct services. Those most frequently reported include volunteer activities, personal counseling services, recreation activities, information and employment referral programs, and senior education programs. Often centers provide space for other social agencies within the community to asure that a broad range of all services is available to the older person who comes to the center.

The impact of these title III programs can be measured by ways in which project services meaningfully affect the lives of older Americans:

In Pennsylvania, 69 older persons previously living in nursing homes are once again living in private homes and participating in family and community life. This was made possible by a foster-home service program funded under title III.

In Maryland, an employment counseling service has found jobs for 438 older persons in the first nine months of its operation.

In New Mexico, a group of senior volunteers have made over 300 home visits to other elderly shut-ins. These volunteers have arranged for shopping services, homemakers and nursing services, and library services for these shut-in people.

In one State, older persons are effectively serving on the staff of the State agency on aging, while other older people are being employed to provide information and referral services to the aged in seven rural counties of the State.

In Texas, an elderly lady bedridden with severe arthritis was provided with needed homemaker services during the illness of her husband who had been caring for her. With additional rehabilitation, this woman is using a wheel chair and is learning to walk again.

As a result of a survey conducted by a local council on aging in Louisiana, 123 older persons with serious physical handicaps or ailments are now being visited by Public Health nurses or have been put in touch with physicians who can provide needed medical care.

The Administration on Aging has actively assisted States in developing programs for older people. Fifteen workshops have been conducted for the staff personnel of the State agencies to develop and exchange information concerning ways of implementing the title III program. Similar training sessions and workshops for community leaders have been conducted in many parts of the country. Project guidelines have been issued covering a variety of program areas such as senior centers, community organization, and information and referral programs. These guidelines will assist local communities in the development of successful programs in aging.

Progress in the States and at the local level has been significant. There are, however, still many problems needing further attention. For example, many State agencies need additional staff to utilize fully the resources available to them under title III of the Older Americans Act. Some areas within States lack effective local bodies to plan, conduct, and coordinate services and programs for the aged in their communities. Substantial shortages of qualified personnel to staff local programs still exist. There is, however, a consensus among the States that the Older Americans Act has done much to meet some of these problems. Local agencies now have available to them the technical assistance and financial means to plan and carry out needed programs for older people. For the first time, many parts of the country have available the resources and responsible organzations to improve the lives of their older residents.

DIRECT PROJECT GRANT PROGRAMS

The Older Americans Act of 1965 recognized the continuing need to conduct research into the field of aging and to demonstrate the results of this research in selected experimental projects. The Act also recognized that aging programs can only be successful if there are available the skilled personnel to administer and provide the services required by the elderly in the community.

Title IV of the Older Americans Act created a research and demonstration grants program to investigate the techniques and methods required to develop and improve programs for older people. Title IV programs differ from title III programs because they concentrate on the innovative and experimental kinds of projects. Projects funded in the title IV program do not replicate, duplicate, or expand existing facilities, programs or activities. In addition, research and demonstration projects meet the criteria of originality and national significance since these projects must ultimately provide data, information, and experience of significant value to others than the grant applicant and participating organizations.

This program, begun in January 1966, funded its first projects in April of 1966. During the year over 125 formal grant applications were reviewed by the Administration. At the end of the year, 39 project grants had been awarded to agencies and institutions in 25 States. Six applications were referred to other grant programs. Action was deferred on some 15 of the applications pending the review of additional information about the proposed projects. Fifty-two project applications were not recommended for funding by technical review committees convened to evaluate proposed projects in the light of the Administration's program priorities.

Research activities have included the study of the different social, cultural, and migratory problems of the aged. This study will analyze the effects, for example, of migration upon the capabilities of communities to provide additional services for a growing aged population. Research efforts are investigating the best ways of organizing services for the elderly, with particular emphasis upon the interrelationships of various agencies and the optimal sizes for such agencies.

Pilot-project demonstrations are testing new concepts in senior center development. Study is being made of the mobile center concept designed to reach into otherwise isolated urban neighborhoods or into smaller communities which would ordinarily lack sufficient resources to maintain a permanent senior center. Another innovative project involves the feasibility of preparing food in a central facility and distributing the food to satellite centers or to public housing residents. New information and referral techniques are being developed in which members of senior centers systematically visit isolated older persons in

their homes to provide information and assistance. Specialized televised programs aimed specifically at the aged make available information and referral experts ready to answer the questions of older people over the telephone.

Researchers are identifying an ever increasing number of gaps in our knowledge about older people and the ways in which services can be provided for them. There is need, for example, to develop cost-effectiveness data on existing program operations which affect the elderly. Such data would not only help to evaluate the effectiveness of current expenditures on behalf of the age, but would provide essential information needed to guide program development and implementation. Thorough study needs to be made of theories of and actual factors associated with personal and social adjustment in retirement. Existing theories, often contradicting each other, are used to justify differing approaches to the problems of aging and the aged. Little is known about the relationships between the individual and his family, old-age clubs, mixed-age social groups, housing arrangements, and crises such as widowhood and relocation. More study needs to be given to the phenomenon of retirement. Specifically, study must be made of those activities which can serve as effective replacements for the activities associated with previous life roles, particularly in the work role. The need for practical solutions to the variety of problems which older people have and the need to differentiate the problems of the sub-groups within the older population will continue to be the focus of the research and demonstration program of the Administration on Aging in 1967.

Title V of the Older Americans Act authorized the Administration on Aging to support specialized training programs for persons employed in or preparing for employment in programs affecting older people. It is a policy of the Administration to support the training of professional and technical personnel in areas of aging not covered by existing training grant programs.

The training grants program of the Administration is focused upon the following areas within which there is desperate need for personnel and for which previously existing support is either lacking or inadequate:

Broad planning and administration in aging for work at the Federal, State, and local levels. Career training is needed at master's and doctoral levels; short-term training for the currently employed.

Personnel for planning, administering, and managing *retirement housing, retirement villages, and homes for the aged.* Career training at the master's level and a variety of short-term courses are needed.

Planning, administration, and program supervision for personnel and staff of *multiservice centers for older people.* This field, like the two preceding, is rapidly growing.

Training for *specialists in aging within such professions as recreation, religion, adult education, architecture, and retirement preparation* is an urgent need.

Preparation of *faculty personnel in applied social gerontology* and within other established professions.

Leadership training for *members of State and community committees* on aging and for older adults who wish to become active in their communities.

Training for *semi-professional and technical personnel* to serve under professional direction as library and recreation aides, aides in housing projects, homes for the aged, and in institutions and a variety of other ways.

The Administration on Aging has supported various types of projects grants for training. Training grants are made to educational and other appropriate institutions and agencies to help initiate, expand, or strengthen instructional programs. Traineeship grants are made to similar institutions for stipends, scholarships, and fellowships to students. Short-term training grants are being made for personnel currently employed in aging or in related fields. Training institute and conference grants are available to appropriate agencies and organizations for the training of specialized personnel to share and exchange information or improve skills. Curriculum development grants are used to develop curricula, teaching and training materials and methods, and other efforts which will strengthen training programs in aging.

Fifty-six applications for projects were received between January and November 1966. All applications which are compatible with the Administration's priorities and policies are reviewed by technical review committees which make

recommendations to the Commissioner on Aging for final action. Fifteen of the applications received (including 3 contracts) have been supported. Twelve applications were referred because of their relevance to the programs of other Federal agencies for support. Twenty-five were not recommended for approval by the technical review committees, and three applications are still awaiting review by committees.

The training grants program of the Administration is coordinated with the training grants of other Federal agencies. Regular communications are, for example, maintained with the National Institute of Child Health and Human Development, the Vocational Rehabilitation Administration, the Office of Education, and the U.S. Public Health Service. The purposes of this communication is to consolidate approaches in meeting training needs, to maintain the clearest possible division of program responsibility, and to avoid duplication of effort and support.

THE FOSTER GRANDPARENT PROGRAM

The Administration on Aging also administers a unique program which employs men and women, over the age of 60, whose incomes are below the poverty index to provide personal care and attention to children who are living in various types of hospital or institutional care arrangements and who have been deprived of the affection of a concerned adult.

The program, which is operated under contract with the Office of Economic Opportunity, was started in 1965. By the end of 1966, 37 project grants had been made which can employ 2,458 foster grandparents in over 85 institutions throughout the country. The Office of Economic Opportunity approved 21 of these projects in September-October 1965, 12 projects in May 1966, and 4 more projects since that time. Over $5.75 million in Federal funds have been used to support these projects. Over 100 other communities, institutions, and other organizations have expressed an interest in starting foster grandparent programs.

The foster grandparents work in many different settings including foundling hospitals, pediatric wards of general hospitals, institutions for retarded children, day-care centers, facilities for the physically handicapped, and in institutions for the emotionally disturbed. Experimental programs are also underway in special classes for the retarded, and in correctional institutions.

The program has given new meaning to the lives of the grandparents and of the children. In addition to supplementing their incomes, the program enables the grandparents to provide valuable services to many youngsters. One grandparent has said, "When you see a little fellow reach out for you, you get a good feeling, you have really done something." The program has enabled over 70 percent of the children to be helped and their behavior has improved. Some retarded children have learned to walk; others have improved their personal habits, since now there is someone who cares about them. Most important, there are many children who have learned to smile again. Perhaps just as important, communities and institutions are taking a new look at the contributions which can be made by older people when given the opportunity to remain productive.

The Foster Grandparent Program has also helped to identify a variety of barriers to opportunities for older people to remain productive in community life. Transportation, for example, was one of the major concerns to many persons interested in participating in the program. Because of the low-income position of applicants for foster grandparent positions, many do not have automobiles. Many persons, particularly older women, have not learned how to drive. Local communities and project applicants have, however, learned to overcome transportation and other problems to assure that older people interested in the program can participate.

Interest in the Foster Grandparent Program on the part of older people is continually growing. It has been estimated that there have been at least eight applicants for each grandparent position available. One project reported more than 500 applicants for some 38 positions. Turnover in these positions has been very low, only about 10 percent. Absenteeism has also been very low; institutions report that the absentee rate for grandparents is lower than for regular employees. The Foster Grandparent Program has clearly demonstrated that there exists a viable role for older people in service-oriented programs.

ACTIVITIES WITH OTHER FEDERAL AGENCIES

The Administration on Aging is actively working with other Federal agencies to encourage closer coordination of the programs which affect the lives of older Americans. The President's Council on Aging provides a forum for the exchange of information and ideas about aging and aging programs. The Executive Committee of the President's Council is chaired by the Commissioner on Aging. In 1966, the President's Council on Aging, working through its Executive Committee, met three times to discuss ways in which communications and closer cooperation among the Federal agencies could be improved. The Council explored in depth the existing mechanisms for the exchange of information and statistical data about older people. At the end of the year, the Council was studying new ways to improve these mechanisms, particularly those related to statistical reporting of data gathered from program operations. Within the Department of Health, Education, and Welfare, the Departmental Committee on Aging serves to bring together the thinking and program planning of the constituent agencies, in order that gaps in services can be readily identified and action taken to fill these gaps. This Committee is actively engaged in the current exchange of program information about the many new programs for older people in the Department.

The Administration on Aging has also engaged in a number of cooperative activities with individual agencies to promote better coordination among various programs which benefit the aged. For example, the Commissioner on Aging has joined with the Commissioner of Vocational Rehabilitation in urging closer cooperation between State agencies on aging and State vocational rehabilitation agencies to further the development of rehabilitation services for older persons. The Administration has joined with six other Federal agencies to finance a survey entitled *Susceptibility to Health Fallacies and Misrepresentations*. The purpose of the study is to identify some of the reasons for the willingness of many older people to accept the blandishments of the health quack. The Administration is currently working with the Bureau of Outdoor Recreation to develop programs which recognize the recreational needs of the elderly in urban areas. Other discussions are being held with the Department of Housing and Urban Development and interested private groups to explore ways of overcoming the architectural barriers which hamper the use of community facilities and other buildings by older people. The Administration on Aging is working with the Office of Economic Opportunity and the Public Health Service in the development of a home health aide program in which older people are being trained and employed as home health aides. The Administration's role in this program is to provide technical assistance to the Public Health Service and local projects in matters involving the recruitment, selection, training, and employment of the older home health aide trainee. The Administration is also working closely with the Public Health Service in developing suitable training programs for nursing home administrators. The Administration on Aging has held meetings with the Federal Trade Commission concerning areas of mutual interest on problems affecting the older consumer such as land sale frauds, burial plans, credit abuses, direct mail sales programs, and charity rackets. The Federal Trade Commission is providing the Administration with case studies in these fields as they relate to older consumers. The Administration has started a joint consumer information program with the Food and Drug Administration. AoA has proposed to join with FDA in programs which will advise older consumers of sound purchasing techniques, what to avoid, and how to protect themselves from fraud and quackery in buying. The Administration has also been working with the Bureau of Federal Credit Unions in the development of information programs and materials for the elderly about the use and abuse of credit. In 1967, the Administration plans to expand these and other activities to areas not now receiving adequate consideration in aging. For example, the Administration expects to work closely with the new Department of Transportation in the hope that greater interest in the transportation needs of the aged can lead to new ways of meeting these needs.

THE ADVISORY COMMITTEE ON OLDER AMERICANS

The Older Americans Act provides for a committee of 15 prominent citizens and leaders in the field of aging to advise the Secretary on matters relating to his responsibilities under the Act. The Advisory Committee has held several meetings in 1966 to review the objectives of the Act and to develop recommenda-

tions for the Secretary. The Committee earlier in the year agreed to the following overall goals to the basic planning of present and future programs for older people:

Provisions for favorable social, economic, and political environments to enable the older American to participate fully in American life and in society in which he lives.

Realistic programs for older people in health, housing, recreation, community service, employment, income maintenance, education, and rehabilitation.

Creation of real opportunities for older people to live more meaningful lives in retirement, to express themselves, to serve others, and to remain independent with dignity.

The Advisory Committee on Older Americans has begun a report of goals and objectives for older Americans for submission to the Secretary of HEW.

CLEARINGHOUSE OF INFORMATION

An important role for the Administration on Aging is serving as a clearinghouse for information related to problems of the aged and aging. In 1966 the Administration undertook new efforts to improve the visibility of programs for older people. Plans were drawn for a new series of publications entitled, "Designs for Action for Older Americans." The purpose of this series is to provide community officials and organizations with information about successful aging programs now operating in other communities in the United States. Each publication will discuss one kind of program, how the program was developed, and the organizations used to implement the program. The series, now in production, will offer 25 "designs" in 1967.

Two new publications were also released in 1966. The first, "A New Day for the Older American," was published in connection with Senior Citizens Month. This pamphlet contained a guide for community action on behalf of older people. The second, "Facts About Older Americans," was a compendium of statistical data designed to characterize the problems of the elderly including their income position, living arrangements, marital status, population and other demographic data.

The first national Directory of Senior Centers was published jointly by the Administration on Aging and the National Council on Aging. This directory was prepared as a sourcebook for members center programs, other workers in the field of aging, and for older people and their families interested in locating senior centers. The 201-page directory was issued in the spring of 1966. Another pamphlet, entitled, "Is Your Community Ready?" will assist community planners and interested organizations and encourage action for older people in local communities under the title III programs authorized by the Older Americans Act. The pamphlet, scheduled for production in February 1967, will encourage local groups to contact State agencies for advice and assistance in getting programs started.

The Administration on Aging, in cooperation with 15 other Federal agencies, State and local units on aging, and private organizations throughout the country, undertook to promote Senior Citizens Month in May of 1966. This program provided a framework for a multi-agency, multi-media campaign concentrated in a short-time period to bring to the attention of the public the various needs and problems of the older American. Some 666,300 pieces of promotional and informational material were distributed through press, TV, and radio channels. The Administration is already laying its groundwork for the 1967 observance of Senior Citizens Month and is planning to expand its information activities to support this program.

OFFICE OF EDUCATION

Title III of the Elementary and Secondary Education Act (P.L. 89–10) provides nonmatching grants directly to local education agencies to stimulate and assist in (a) the provision of vitally needed educational services not available in sufficient quantity or quality, and (b) the development and establishment of exemplary educational programs to serve as models for regular school programs. This program gives special consideration to projects that are truly innovative as well as being of high quality and responsive to local needs.

Under the provisions of Title I of the Library Services and Construction Act (as amended by P.L. 89–511) the Library Services Branch provides information

and advice on programs oriented to the aging which are conducted by State library agencies; assists training institutions with programs designed to give librarians special skills needed to meet the special library needs of older persons; maintains liaison with other Federal agencies and organizations concerned with the aging; assists in conferences of professional and lay leaders concerned with library-sponsored activities for older people; and provides grants for the improvement of public library services.

The Division of Adult Education Programs administers programs for the training of adults in basic education, community service and continuing education, and civil defense education and provides information and consultative services for these programs—all of which include older persons. For example, in fiscal year 1966, approximately 20 percent of the total enrollment in basic education classes were age 45 or older. Under Title I of the Higher Education Act (P.L. 89–329) there were 12 programs in 10 States dealing with problems of the aging and focusing generally on (1) increasing the intellectual and community involvement of these older persons, (2) broadening their economic knowledge and/or employment opportunities, and (3) making available to them the best possible health information and medical treatment.

Vocational education training programs provide training and retraining for persons of all ages in occupations in health, trades and industry, offices, distribution and marketing, home economics, and agriculture. These programs serve increasing numbers of older persons who need basic learning skills, to improve old skills, or to develop new skills in order to advance employment opportunities. Agencies and institutions developing these programs continue to be encouraged to employ older qualified persons as teachers in vocational training programs.

Programs under the Manpower Development and Training Act, in which there is joint cooperation among Federal agencies, have provided for training and retraining of older workers to develop or improve their occupational skills; however, the 1966 Amendments to the Act (P.L. 89–792) directed that more attention and resources be expended on the problems of the older worker who with training and subsequent employment can make many contributions to the labor force. Of the total enrollment for training in 1966, 11.8 percent were age 45 or over and it is expected that the percentage participation of this group will increase.

The Office of Education funded and monitored a half dozen studies relating to aging during fiscal year 1966. Specifically, studies such as the effect of participation in public affairs, and factors related to the participation of adults in education programs were undertaken. More than $200,000 in Federal funds were directed toward these adult and aging studies.

Vocational education programs provide training and retraining opportunities for all age groups in occupational areas such as distributive education, home economics, office skills, health and related services, and several traditional trade skills categories. These on-going programs are expected to, and have been providing older Americans with newer skills related to the rapidly changing needs of the market.

Food and Drug Administration

All of the activities of the Food and Drug Administration are designed to safeguard the lives of consumers and, therefore, have a significant impact on the health and well-being of elderly people. There are nearly 19 million Americans aged 65 and over, representing approximately ten percent of the Nation's population. The aging are particularly susceptible to fraud and quackery in these areas. The first type involves worthless therapeutic or diagnostic devices which are represented as preventing, curing, or diagnosing ailments to which all are subject in advancing years. During FY 1966 FDA initiated 70 seizures of medical devices which were substandard, inadequately labeled or bore false and misleading claims.

Many vitamins and nutritional supplements are unscrupulously misrepresented as being of special value to the aged. This is a problem that involves not only large manufacturers of the basic chemicals and the broadly mechandised brand-name products. The field is also cluttered with small-time pitchmen, quacks, faddists, and know-nothings who turn nutritional hypochondria into exaggerated profits. The aging consumer is very vulnerable. In order to carry out its mandate to protect the consumer from economic as well as medical frauds, the FDA has proposed and published revised labeling regulations and new

standards for fortified foods and vitamin and mineral supplements. The new regulations are designed to provide the consumer with more information about foods purchased for weight control, for dietary supplementation, and for other special dietary needs, such as controlling salt intake.

A third area is medical quackery which includes drug products that are ineffective in treating chronic or degenerative diseases but which are promoted by extravagant claims. FDA is responsible for the quality of drugs such as the antiarthritics, the hematinics, the diuretics and the anticoagulants to insure that they are manufactured according to the highest standards known.

In May 1966, FDA played a significant role during Senior Citizens Month with special publications and slide shows, radio and television spots and effective exhibits. Greater emphasis is being placed on education of the aging on the warning signals to look out for in the purchase of health products and services.

Drug manufacturers spend an average of $3,000 on advertising directed to each prescribing physician in the United States. During Fiscal Years 1967 and 1968 FDA will increase its efforts to maintain constant vigilance over the advertising of products promoted for use by senior citizens and will exercise its full power to assure corrective action on those products bearing fraudulent or misleading claims, and those which prove to be unsafe or ineffective.

FDA and the Administration on Aging are jointly sponsoring a series of regional conferences to educate leaders in consumer education on the special consumer problems of older people.

On the basis of experience during previous years, it is estimated that FDA devotes approximately 30 percent of its program efforts to the protection of the aging.

Public Health Service

Bureau of Health Manpower

Division of Dental Health

The Division of Dental Health provides consultation and technical assistance to State and local health agencies to stimulate interest in the development of service programs for the aged. Efforts are being continued to explore various approaches to the organization of such programs, including the development of demonstration projects in hospitals, health departments, nursing homes, and private homes. Research projects supported for the purpose of improving the oral health status of the aged are now being applied in these demonstration projects. These include an assessment of the needs of older people, the feasibility of providing comprehensive dental services to this population group, and the development of portable dental equipment. Continuing studies include investigations relating to the cost and economic feasibility of providing dental care through a coordinated community program, the role of the dental hygienist, and a determination of decision making criteria employed by dentists providing care for homebound patients.

Division of Nursing

Many of the activities of the Division of Nursing are directed toward improving the understanding and skills of nurses working with geriatric patients, as well as to stimulating the development of services for homebound patients. Some of the projects supported by the Division include the extension of community nursing services to areas not formerly served, study of nursing care being supplied to older people in their homes, methods of measuring patient progress, staffing needs of nursing homes, and information on the availability of nursing care of the sick at home. Training in the nursing care of geriatric patients is also being supported, particularly short-term courses in restorative nursing, and the nursing care of coronary and stroke patients.

Division of Health Manpower Educational Services

The Division supports training programs related to aging in three categories. Graduate public health training grants were awarded to Boston University, Tulane University, and the University of Michigan for the implementation of training programs for public health workers. Special purpose training grants were awarded to the University of California at Los Angeles for the preparation of 8 public health professionals and to the University of Michigan for 4 public health professionals. Short-term training grants were awarded to many institutions and agencies to increase the competence of health professionals in working with the aged and the problems of aging.

National Center for Chronic Disease Control

Activities related to aging are conducted in the National Center for Chronic Disease Control.

The Kidney Disease Program is responsible for developing methods and testing programs to prevent, detect and treat disease of the kidney. Approximately 85 percent of the estimated 100,000 deaths per year from kidney disease occur in persons over 45. The development of widely applicable methods of early detection, diagnosis and treatment can significantly reduce this mortality figure.

The development of projects for automating multiple screening as part of periodic health appraisal and for validating screening tests are also being supported and directed and studies are underway to establish the value of early detection of chronic disease. A plan has been developed for applying an automated casefinding system in a community setting. Similarly, a Preventive Health Services Program plan was developed for the United States Congress. Training in the establishment and operation of sophisticated casefinding clinics is now being supported and a second series of seminars on the laboratory aspects of chronic disease is being conducted for State health department chronic disease and laboratory directors. Directly or indirectly these activities all bear upon improving the health of the aging and aged.

Cancer illness and mortality has increased with extended longevity of the American people. If current trends continue, cancer will afflict one in four Americans. More than half of all cancer deaths in 1966 were among persons over 65. To combat this trend, the Cancer Control Program is stressing the need for regular physical examinations; demonstrating methods of early detection, diagnosis, case management and rehabilitation; developing ideas for improving every aspect of care of the cancer patient; and providing opportunities for medical and paramedical personnel to obtain training in applying procedures of known reliability. In the field of breast cancer, regular examinations and self-examinations are being encouraged along with the use of a new X-ray technique for early examination called mammography. To combat uterine cancer, a $7 million program is underway to demonstrate the value of providing Pap tests for the more than 8 million women admitted to hospitals for any reason. Another program is encouraging the use of cervical cytology as a routine procedure in the office of the family physician. Physicians in 32 States are now participating. Five hundred persons are being trained in cytotechnology each year. New concepts in cancer detection, medical instrumentation and identification of population groups whose risk of cancer is high are important aspects of the developmental program. All of these are long-term programs aimed at making the best knowledge of cancer control effective for all Americans.

Eighty-three percent of all diabetes and 85 percent of all arthritis is found in persons over 45 years of age. Many research activities and studies supported by the Diabetes and Arthritis Program stem from the health problems associated with these two diseases. Some of the projects are directed toward the perfecting and evaluating of equipment and techniques for detection and diagnosis. Also, through the loan of equipment and supplies or the assignment of personnel, diabetes casefinding is being supported in more than three-fifths of the States. Consultation to provide for the improvement, expansion, or development of diabetes and arthritis programs is available to all States and communities. Professional and patient education are included in the activities of the Diabetes and Arthritis Program.

By providing professional, technical, and financial assistance to States and other agencies, the most effective methods of prevention, diagnosis, and treatment of cardiovascular diseases most prevalent among the aging and aged are made availble by the Heart Disease Control Program through its cardiovascular programs for adults: congestive heart failure, coronary heart disease, hypertension, peripheral vascular diseases, and stroke. Research, services, training and education are important elements in each of these programs. Field epidemiological studies to identify etiological factors, biomedical instrumentation and engineering to develop techniques for early casefinding, improved laboratory methods for more effective patient management, and demonstration projects involving intensive care units for cardiovascular and stroke patients, are among the special interests of this Program.

Demonstration and program development activities of the Neurological and Sensory Disease Service Program are focused on priority areas where maximum benefits result. Early detection and prevention of blindness through glaucoma screening programs continue to be among the important activities bearing on health of the aging. Seven Public Health Service ophthalmologists were assigned to State health departments (Iowa, Minnesota, Missouri, Wisconsin, Oklahoma, Florida, and New York) to establish or expand screening programs for detection of eye disorders, especially among older adults. The Program continues to be engaged in the Collaborative Glaucoma Study, a multiclinic study being conducted by five teaching institutions—Johns Hopkins University, New York University Medical Center, Iowa University, Washington University at St. Louis, and the University of California. In another project, the Oregon State Board of Health is collecting information on the outcome of referrals from a screening program to detect visual disorders among residents of nursing homes and homes for the aged in Portland and four nearby counties. Nationwide availability of technical films for medical schools, health departments, and societies interested in special testing or diagnostic techniques has been made possible by project grants and contracts. With funds provided by the Program, the film "Muscular Dystrophy and Related Conditions: Differential Diagnosis" was produced and distributed. A film on the use of tonometry by the general practitioner in screening adults for glaucoma was produced and distributed under contract with the Public Health Service Audiovisual Facility, Communicable Disease Center, Atlanta, Georgia. With grant support from the Program, the Houston Speech and Hearing Center is providing casefinding, evaluation, and rehabilitation for inmates with aphasia in eight nursing homes in the Houston area.

The activities of the Chronic Respiratory Diseases Program emphasize the application of existing methods for the rehabilitation and intensive treatment of cases of emphysema and chronic bronchitis because studies have shown the worth of those methods in alleviating the suffering associated with the advanced stages of the diseases. The effectiveness of medical management of early and moderate cases has not been well established and consequently the Program is exploring their possibilities. Since emphysema and its associate, chronic bronchitis, affect, in particular, adults past the age of 40, current efforts are directed mainly to individuals in the middle and old-age groups. In addition to the direct support of demonstrations in rehabilitation intensive care and casefinding, the Program campaigns intensively for the dissemination of useful knowledge that can be translated into improved services for the management of respiratory cases, and provides consultation and technical advice to other official and voluntary agencies in this respect.

The newest activity in the National Center for Chronic Disease Control is multicategorical and is directed toward the development of models for unified chronic diseases planning. This activity includes the development of 16 community health planning projects for heart, cancer, stroke and related diseases. It is concerned also with maintaining liaison and establishing other inter-divisional relationships with the Division of Regonal Medical Programs and with other components of the Public Health Service having related programs.

The National Center for Air pollution Control is continuing its support for studies of the effects of air pollution on chronic respiratory and chronic nonspecific respiratory diseases, of which there is a high prevalence among the aging and aged. Program project grant authority was authorized in the Clean Air Act to provide for the support of State pollution control programs and other projects to demonstrate effective air pollution control measures at the community level. The aged represent a population group more likely to suffer ill effects from exposure to air pollution, and the aged will benefit greatly from the research, abatement, and training activities being conducted and supported by their Center.

National Center for Urban and Industrial Health

Aging programs in the National Center for Urban and Industrial Health include research conducted or suported by the occupational health program which is concerned primarily with the pathophysiologic response of man to his environment. In this connection, clinical studies are being made in which age is the most important nonoccupational variable. Among the projects now being supported are investigations of chronic chest diseases in bituminous coal miners, health hazards in uranium mining and milling, and the effect of a hot environ-

ment on the elderly. Other research projects supported by the program include a study of the status and rehabilitation of the farm cardiac, of hearing loss in industry due to noise, and of the aging lung.

The injury control program is supporting several research projects basic to the health and well-being of older people. Included are a study which provides for the screening of women for osteoporosis, a bone disease, and evaluation of a new diagnostic device used to measure osteoporotic change, and two studies which relate to safety in nursing homes. One of the studies on nursing home safety is directed to determining means to reduce fire hazards and to provide safeguards for preventing accidents. The other study is concerned with testing the durability of flame retardancy of fabrics after normal usage. These are fabrics used for wearing apparel, bed clothing, and decorating. In addition, experimental research has been programmed in the injury control program's research laboratory on various types of motor and perceptual impairments in driving among the aged. Consultation is also given to State health departments, other Federal agencies, and other public and voluntary groups concerned with the development of accident prevention programs for services and public education. The program also assists the agency involved with the development of materials relating to accidents and the aged, and provides courses in the "Public Health Aspects of Accident Prevention," which include material relevant to the problems of older people. These courses are conducted by health departments, universities, and schools of public health. Similar seminars are being developed for selected practitioners in the field of public health and for personnel in schools of nursing and public health. Close liaison is maintained with experimental groups in gerontology.

The special environmental hazards program provides consultation to several groups planning services in programs for the aging and aged. Consultation in the field of housing is given to other programs, agencies, and departments. Publications are issued on recreational areas, and mobile home and trailer park sanitation.

National Center for Radiological Health

A major portion of the research efforts of the National Center for Radiological Health is concerned with the long-term effects of low levels of radiation exposure. Primary interests relate to the study of long-term effects as a function of radiation dose with the ultimate aim of providing better scientific bases for population radiation standards as well as gaining more fundamental knowledge related to the mechanisms of cause-effect relationships and methods by which radiation damage may be diagnosed early, prevented, mitigated or treated.

The primary approach is to study the relationship between radiation dose and the incidence of disease and disability in human population groups, i.e., epidemiologic studies, with supportive and complementary experimental studies using animals and various biological systems. Nonspecific life-span shortening and acceleration of aging are among the most important consequences of the long-term somatic effects of radiation exposure in population groups. Consequently, much of our research, directly or indirectly, relates to the problem of "aging" and the closely interrelated problem of radiation carcinogenesis.

The major epidemiologic study effort as related directly to aging concerns the studies of the Atom Bomb Casualty Commission in which life-span studies are being done on the incidence of disease and disability among the survivors of Hiroshima and Nagasaki. A major study parameter is whether nonspecific life-span shortening or accelerated aging relatable to exposure from the atom bomb will be found in the survivors.

BUREAU OF HEALTH SERVICES

Division of Medical Care Administration

The passage of Medicare was an important step forward in meeting the health needs of the sick aged in the population. However, provision of therapeutic services for the aged is only part of a comprehensive health program for this age group. Another vitally important facet of such a program is the provision of preventive services to protect the health of the majority of the elderly who are in apparent good health. Early detection and prompt management of chronic diseases can do much to prevent or minimize disability that would otherwise occur. Moreover, since chronic diseases frequently have their onset during the middle years, disease detection activities for adults can be viewed as a crucial

health conservation measure which can have a positive influence on health status in the later years. During the past year activities have been focused on the development of health protection programs for adults, including the aging and the aged, and on the training and orientation of health practitioners who serve the health needs of individuals in these age groups.

A major objective in 1966 was to assist States and communities in the development, improvement, or expansion of effective health services, particularly health protection services, for the aging and aged.

Major efforts were directed to laying the groundwork for the development of demonstration adult health maintenance programs. These demonstrations are of particular significance inasmuch as they are designed to utilize, to the extent feasible, the automated equipment and computer techniques developed through the research and development activity conducted by the Kaiser Permanente Health Plan and supported by a Public Health Service research grant. In the opinion of experts, such use of automation in a health protection center can permit optimum utilization of the time of physicians and other health workers, and can make it possible to conduct health assessment of large numbers of adults in an economic and effective manner.

With the essential groundwork completed, contracts were negotiated for four adult health protection centers. In New Orleans, Louisiana, the program will be carried out by Tulane University School of Medicine, Department of Public Health. The Milwaukee, Wisconsin, demonstration will be conducted under the auspices of the City Health Department. In Providence, Rhode Island, the adult health protection center will be developed by the State Health Department, working in conjunction with the Rhode Island Hospital. A fourth program in Brooklyn, New York, is to be based in the Brookdale Hospital Center.

Professional interest in health protection methods has been stimulated by a Division exhibit entitled *Office Evaluation of the Aging Patient: Disease Detection in Persons Over 45*. The exhibit is aimed at encouraging physicians to use a series of high-yield diagnostic tests and laboratory procedures as an integral part of regular health appraisals of persons in this age group. The message is contained in a 12-minute taped recording synchronized with a series of slides. The exhibit has been shown at national and State medical meetings. An illustrated publication also has been prepared on this subject.

In response to a request for an exhibit to encourage executives to have periodic health appraisals, the above exhibit is being adapted for use at the Canners Convention and the National Exposition for Food Processors. The title will be changed to *Are You Jeopardizing Your Income—Health?* (Income and Health are to be lighted in sequence.) A taped message and accompanying slides, which are appropriate for this audience, are in preparation.

A film entitled *The Critical Decades* stresses the need for health protection during the forties and fifties to insure good health in the later years. This film continues to be in great demand for showings before both professional and lay audiences.

Contracts have been negotiated for the development of health maintenance activities for the aged in communities located in a variety of geographic settings and serving various population groups. For example, in Dade County, Florida, support has been given for an adult health maintenance clinic to be administered by the County Health Department in the South Miami Beach area for a high density, elderly population which is largely foreign born. In contrast, another demonstration is being developed in a sparsely populated, economically depressed rural area in northern New Mexico for a predominantly Spanish-speaking population. A survey was conducted last year in a rural area in North Carolina to determine the health status and health needs of the aged in a low-income public housing project and in a small township. Results of the survey underscored the need for health maintenance services, and led to the establishment, through Division support, of health maintenance clinics throughout the county. Adult health maintenance clinics also are being established in an industrial area in Connecticut.

Division-supported demonstrations have been established in Milwaukee, Peoria, and New Orleans, where the Public Health Service, with the cooperation of the Social Security Administration, is providing health counseling to applicants for Social Security benefits. Preliminary findings indicate that following counseling, there is a substantial increase in the number of persons who carry out adequate personal health maintenance programs. It is anticipated that four additional programs will be established in the coming year. These

demonstrations are expected to provide revealing information on health counseling needs of the aged and on the relative effectiveness of various health counseling techniques.

An illustrated brochure entitled *The Dexter Manor Story* describes a Division-supported demonstration in which a public health nurse and part-time social worker provided health maintenance services in a public housing project for the elderly in Providence, Rhode Island. The demonstration was so successful that the program has been continued with local support, and several similar projects have been undertaken in the State. It is expected that the publication will do much to stimulate the interest of communities throughout the Nation in further investigation of this approach.

A publication entitled *Aging Center at Sinai Hospital* was prepared and distributed. This publication describes a demonstration in which a variety of health maintenance and care services were offered by a community hospital in Baltimore to the medically indigent aged in the area. The publication has been in great demand by health, medical, and social welfare organizations.

The film *Ready for Edna*, prepared for the Division, depicts the broad range of health services needed for the aged, and encourages community support in the creation of these services. Between 50 and 100 requests for showing of the film are received each month from schools of nursing, health departments, hospitals, visiting nurse associations, medical schools, training and audiovisual centers throughout the Nation.

Considerable attention was focused on the development of many approaches to improve the capabilities of practitioners to deal with the health problems of the aged. During 1966, education activities have been successful in providing valuable training to hundreds of future and practicing professionals. The various programs are being developed to provide effective blueprints for the development of similar activities throughout the Nation.

The Division has undertaken a limited number of activities aimed at enrichment of curricula in professional schools as a means of reaching future practitioners. The long-term goal of this effort is to improve health services rendered to the aging and aged through influencing the training of persons who will provide the services.

A significant step in the direction of enriching the curricula of medical schools was taken when a contract was negotiated with the University of Missouri Medical School for the development of an experimental model for a medical school undergraduate teaching program in adult health management. Several other medical schools have expressed active interest in the development of similar programs. Through this activity, future physicians will receive training in the management of the problems of the aging patient, and will be oriented to community services which can be utilized in the course of treatment.

The only medical school geriatric clinic in the Nation has been established with Division support at Tulane University School of Medicine. Through this activity, future physicians are receiving specialized experience in working with the aged, with direction and consultation from physicians especially interested and knowledgeable in this area.

An annual faculty seminar series in gerontology was initiated at the University of Pennsylvania School of Social Work. In addition, a student field placement program for supervised work with the aging also has been established.

Centers for Gerontological Studies in university-based schools of continuing education were established with Division support at the Universities of Georgia and Oklahoma. At the University of Oklahoma, nursing, social welfare, and medical advisory groups were formed to determine continuing education needs of the practitioners in Oklahoma and surrounding States, and five courses or series of courses have been presented. At the University of Georgia, about 70 leaders in health and related professions participated in a 3-day conference early in the year to study and determine training needs. Subsequently, a series of fifteen 1-day seminars in all aspects of aging was held for the faculty who will be teaching both the continuing education courses and other undergraduate and graduate courses related to the University's new gerontology program. Planning and administration of the center are funded through this Division. The courses offered are funded largely by Public Health Service short-term training grants.

In the developmental stage are plans for the establishment of several additional gerontological centers. It is expected that such centers will serve as a valuable resource through which practicing professionals can receive continuing education in gerontology.

A continuing education project at the University of North Carolina School of Nursing trained approximately 100 nurses in a variety of positions (teaching, supervisory, and staff) to better understand and work with problems of the aging, and further helped to train them to teach their colleagues. As part of the project, a manual is being developed which will analyze the methods and tools of instruction that were used in this teaching program.

The Practitioner and The Elderly, the first in a series of four volumes to be published under the title *Working with Older People: A Guide to Practice*, was made available for distribution in the fall. It is expected that the additional volumes will be concerned with the biological, sociological, and psychological aspects of aging; the third volume will contain groups of syllabi dealing with specific clinical aspects of aging; and the fourth volume will deal with social welfare as it relates to the health status of the elderly. The original body of knowledge upon which the volumes are based was prepared by the Gerontological Society, Inc., an organization which has in its membership outstanding authorities in the many disciplines concerned with health of the aging.

During the past year the Gerontological Society worked in conjunction with the Public Health Service in efforts to implement the newly-developed curriculum training activities. Consultative services in the development of short-term courses in gerontology for practitioners were provided to schools of medicine, hospitals, community health and welfare councils, medical associations and other interested organizations. The veritable flood of requests for assistance in setting up courses received by the Gerontological Society reveals a growing awareness of the need for continuing education activities. A contract has been negotiated with the Jewish Hospital of St. Louis to evaluate the newly-developed training sessions in order to determine the most effective forms of presentation of the curriculum material.

A Conference on Terminal Illness and Impending Death Among the Aged was held to explore the potentials for programing, training, and education of persons who work with the terminally ill. Participants were unanimous in underscoring the need for further work in this area. Plans are underway to implement specific recommendations made at the conference.

A project funded by the Public Health Service was developed on a contract with Washington University in St. Louis, calling for a national survey of physicians' attitudes toward aging and care of the aged, and the impact of these attitudes on the services rendered.

Another project supported is a study of nurses' attitudes toward caring for the aged. This project is now in its third year. Data from the first year's survey of nursing attitudes toward aged patients and their care is being analyzed and will subsequently be published. Efforts are now focused on the development of methods of measuring attitudes of nursing personnel toward specific patients and their care as well as nurse-patient behavior and interaction. These methods will be pretested.

A contract was awarded to Community Studies, Inc., of Kansas City, Missouri, to develop the design and methodology for a study to determine the effect of changing socio-economic forces on the utilization and provision of health services for the aged. The effect of Medicare was a prime factor to be taken into consideration in this study. Following completion of the study protocol, research grant support was requested and awarded for the recommended investigation. This study is particularly significant because it concerns itself with a hitherto neglected area and offers a valuable opportunity to effectively evaluate these forces at the time of the most radical change in the financing of medical care that has ever occurred in this Nation.

In 1966 the Division, together with the Social Security Administration, defined the role and responsibilities of the State agency in Medicare. Following up on the efforts of interagency work groups, the Division carried responsibility for completing the conditions which hospitals, extended care facilities, home health agencies, and independent laboratories were required to meet in order to participate in Medicare.

Preparing for and supporting the process of certifying hospitals and home health agencies to participate in Medicare, the Division held training sessions for surveyors, provided interpretations of the conditions of participation, reviewed State agency recommendations and advised the Social Security Administration on certification decisions, and sent additional people into the field to support State and regional office personnel. Bi-regional meetings were held in anticipation of the surveys and certification of extended care facilities.

Many Division activities were directed toward the critical problem of the adequacy of the health resources. Through the Home Health Services Formula Grant Program, it assisted in the further development and expansion of these agencies throughout the country. As a result of this program, staffs of State and community health agencies increased by an estimated 1,785 health professional, ancillary, and supporting personnel. More adequate and comprehensive services were added in some 600 counties.

Looking forward to the certification of extended care facilities, Division staff concentrated on clarifying the concept of an extended care facility and explaining the requirements they must meet to participate in Medicare. There were seminars to help staff in nursing homes to improve their skills. A prototype seminar was developed for nursing home administrators in order to help them work more effectively. The Division encouraged successful demonstrations involving cooperative relationships between hospitals and nursing homes. Administrators of 34 hospitals and 107 nursing homes attended an institute in order to discuss this subject.

The Medicare utilization review process has considerable potential for improving quality and continuity of care and better utilization of health resources. Information is collected on the variety of approaches developed to carry out this process and compare the effectiveness of selected methods. Through contracts, the development of community-plans will be encouraged.

One experiment sponsored by the Division in 1966 was the development and testing of an automated data retrieval system which can facilitate the utilization review process and scheduling of hospital admissions.

The Division will play a prominent role in the Medicare appeals and hearing process for denial cases and in reviewing problems related to payment for emergency services.

Several studies have been undertaken to see how, in fact, Medicare has influenced the use of health services. A series of studies will explore how the availability of home health and extended care services affects the use of inpatient hospital services. Another study will explore the effects of deductibles and coinsurance on utilization of health services. Still another will consider supplemental insurance coverage for the aged.

A major effort was made in 1966 to initiate a series of studies which will produce needed information concerning nursing homes and related facilities.

The lack of sufficient health manpower handicaps extended care facilities and home health agencies in their attempts to both increase the amount and improve the quality of their services. Particularly crucial is the need to increase the number of professional personnel. In order to explore ways to accomplish this, the Division in 1966 financed three projects which experiment with approaches to re-attract inactive personnel back into employment.

During 1966 the Division became involved in a program to stimulate the greater use of home health aides. Working jointly with the Office of Economic Opportunity and the Administration on Aging, the Division began exploring, through 12 demonstrations, how older poor workers best could be recruited and trained to work in this capacity.

In response to increasing requests for up-to-the-minute information on the availability of health resources and their certification status, the Division established a Health Services and Resources Data Center, an important potential long-range contribution to program planning.

In 1966 the Division information program stressed the opportunities for quality of care, development of health resources and community planning offered both by Titles XVIII and XIX and by activities supporting these programs. Using all media, the information program was directed toward the health professions and health resources, the general public and special population groups, and governmental agencies, including regional office and State agency personnel.

Basic to adequate planning and effective administration of medical care programs is an understanding of how personal health services may best be organized, used, financed, and improved. Toward this end, the Division supported a number of studies and demonstrations. For example, it considered the economic aspects of programs designed to remove barriers which make it difficult for people to obtain health services and explored organizational implications and relative cost involved in alternative approaches to achieving specific health objectives. The Division considered how high-quality health services can be made available in medically isolated areas, and sought ways to assure that each patient receives the right kind of care at the right kind of time in the appropriate setting.

Division of Hospital and Medical Facilities

A primary objective of the Division of Hospital and Medical Facilities is to stimulate the construction of facilities needed to build up an efficient, well-coordinated network of services for the acute care, long-term care, and rehabilitation of all persons, including the aged and aging. Since the enactment of the Hill-Burton program, the Division has provided assistance for the construction of 69,000 long-term care beds in chronic disease hospitals, nursing homes, and units of general hospitals.

The need for construction of long-term care facilities continues at a high level. As the aging population continues to increase, the demand for adequate nursing home care for them must be met. In addition, the enactment of the Medicare program partially removes the economic barriers to care of the aged. State agencies report that 318,700 long-term care beds, including extended care facility beds, must be constructed, modernized, or replaced. Seventy million dollars was appropriated in 1967 for the construction of long-term care facilities. If continued, this level of financial assistance would stimulate the construction of approximately 13,000 long-term care beds per year.

The aging and aged will benefit also from the construction of modernization of other health facilities under the Hill-Burton program. Hospitals, diagnostic and treatment centers, public health centers, and rehabilitation facilities are used by the aging as well as other segments of the population. Appropriations for these facilities totaled $200 million in 1967.

A demonstration project is being supported which is intended to show that an effective program of geriatric rehabilitation can be implemented in a rehabilitation unit employing skills available to typical community hospitals. Research is being conducted to investigate organizational patterns for the care of the chronically ill in general hospitals. Also, a project is being supported to develop a curriculum of study at the undergraduate level for the potential social worker and nursing home administrator.

In addition, the following services provided by the Division contribute to improved health care of the aged and others throughout the Nation: (1) technical and professional consultation regarding all aspects of facility planning, design, and construction, which is available to States, public agencies, and nonprofit organizations; and (2) guide material relating to the planning, design, equipping, and construction of health facilities, which is being developed and distributed.

NATIONAL INSTITUTES OF HEALTH

National Institute of Child Health Human Development

Research on aging is the search for understanding of a process. The ultimate goal is the application of that understanding to the maintenance of health and the prolongation of the life of the individual.

The Aging Program of the National Institute of Child Health and Human Development, like the Institute of which it is a part, is committed to the attempt to understand what happens to the "whole man" throughout his lifespan. Interest is focused on those events that occur as a result of the aging process. The implications of this are clear, insofar as drawing certain distinctions are concerned. Thus, the program not only has the same sorts of problems as do some of the more traditional lines of research, but others too. Research in aging is not solely about a specific organ or organ system, nor is it solely about a specific disease or diseases, nor yet again only about a particular psychologic or sociologic set of circumstances. Yet all of these matters are the legitimate interest of researchers in aging, making up some of the observable aspects of the process as we now know it.

The life expectancy at birth of a child born today is far greater than that of his counterpart born at the turn of the century. The reasons for this are many, but certainly one of them is the enormous gain in controlling and conquering the infectious diseases of childhood. By contrast, the life expectancy of a man of 50 today is not very much greater than that of a man who attained that age in 1900. It is to be expected that understanding of the chronic diseases that are the major killers in the older age groups will be achieved, and that with that understanding will come better control of those diseases. In time, most of the population will live lives that approach in length what we now recognize as the maximum life span.

However, in the latter years of such lives the impact of the aging process upon the response of the person to stress will be decisive, just as it is today.

The outstanding characteristic of the aging process is that, because it decreases the body's functional ability, it increases in a most dramatic way man's vulnerability to all types of harmful agents and, hence, to disease. What would have been minor stresses in youth become lethal ones in the latter years. The change in mortality rate due to pneumonia illustrates how age may affect the impact of a simple, well-understood disease. The death rate for pneumonia at the age of 20 years is 2 per 100,000; for those over 85 years it is 986 per 100,000. Because of the impact of the aging process on the response to disease, it is vitally important that the aging process be understood.

Not only is the life span affected by the aging process, but so also is the vigor with which life is lived. In other words, in studying aging we are concerned not only with the quantity but also with the quality of life.

In any case, on the fair and justified assumption that a rational distinction can be drawn between the results of disease and the processes of aging, there remain more than enough questions to be answered. We do not know, for example, why cells die, nor how the performance of cells changes either with their own aging or that of the organism of which they are a part. We have learned much about the responses of organs and organ systems to aging in functional terms, but we need even more precise knowledge about these matters. We do not know which factors in the early life of the individual tend to increase his longevity. And we cannot yet say precisely how such factors as life style, accident, diseases, and stress affect the rate of aging.

Because of the complexity of the problems posed by aging, research in the field must draw on the skills and knowledge of many disciplines. The research goals of the Aging Program are, in fact, concerned with matters as diverse as the cellular biology of aging and retirement as a phase of human life.

Extramural Programs.—The Aging Program supported 64 research grants at a cost of $3,210,554 during Fiscal Year 1966. The area of interest covered by these research grants was broad, from molecular and cellular problems, through physiologic and medical aspects, to analytic studies in the social and behavioral sciences. About one-fourth of the funds went to behavioral and social research, while the balance supported biologic research. Some of the research projects will be described here under individual headings.

Molecular Aging

Collagen is one of the major structural proteins of the body that shows systematic molecular changes with age. It is the major protein constituent of the body's suportive tissues and, in fact, accounts for about one-third of all the protein found in the body. Found in the skin, blood vessels, tendons, and bones, it forms the supporting network of fibers in which most body tissues and organs rest.

In addition to its general interest for investigators, collagen is a particularly interesting target for research in the field because changes in both its character and amount are apparent in a number of conditions associated with the elderly. These include arteriosclerosis, osteoporosis, and even the wrinkled, sagging skin seen in the very old.

Many investigators, including institute-supported investigators at the Albert Einstein College of Medicine, are studying the structure of this substance which consists of long linear molecules connected one to another by cross-links. These links give the protein its stability and also affects its physical and chemical properties.

It is known that the number of cross-links between collagen fibers increases as the body ages. Indeed, this multiplication of cross-links has been held to be probably responsible for the changing properties of collagen with age. The nature of these links, however, and the factors that influence their formation and breakdown is not yet entirely clear.

Two years ago, the biochemists at work on the problem at Albert Einstein found certain chemical groups in collagen that might be involved in the cross-linking process.

Now they have isolated four of these groups and have identified two of them chemically. One of these identified compounds they have named enosaline. It has been found that the enosaline on one collagen molecule can react chemically with the enosaline on a neighborhoring collagen molecule to form a paired compound that makes up a firm structural link between strands. These investigators have also been able to develop procedures for pinpointing the location of the cross-links under the electron microscope and have shown that they occur at the ends of collagen molecules. These experimental findings are important

steps in our understanding of the structure and biosynthesis of the body's structural proteins and of the changes that occur in them with maturation, aging, and disease.

Lysosomes and Age Pigments

An investigator from the Baltimore City Hospital and the Johns Hopkins University School of Medicine has conducted research that throws some light on the nature of the pigmented material that is known to accumulate in the cells of aging animals. This yellowish-brown pigment is particularly notable in cells of the heart and the nervous system.

The research produced evidence that supports the view put forward by several groups of scientists that this pigment is related to the lysosomes of cells. Lysosomes are small vacuoles within cells that contain enzymes that are capable of digesting many cellular components. Ordinarily, however, the membrane that forms the wall of the vacuole prevents the enzymes from acting on the material that surrounds the vacuole.

It was found that in a number of conditions, such as starvation and deprivation of hormones, the lysosomal wall may break down. Lysosomal enzymes then digest the cellular material immediately around it.

When all this material has been digested, there remains a complex of lipid and protein that is indistinguisable from the aging pigment. The investigator suggests that it is such lysosomal activity which, over the years, finally results in the accumulation of pigment that is found in the tissues of elderly persons.

Immune Theory of Aging

A study of immune phenomena in aging is under way at the University of California. Its object is the amassing of evidence for or against the immune theory of aging.

Observations indicate that man may produce immune responses to his own proteins and does so increasingly with age. The theory states that these events may be important in the aging process, since such reactions may damage the organs and tissues containing the proteins against which the immune response is directed.

There is some evidence to support this view. The first such evidence is the very fact that there is an increased incidence in immune reactions against one's own proteins with age. The second is the increased frequency with age of the occurrence of amyloid—a substance that is known to be associated with excessive immune reactions.

As a means of testing the theory experimentally, the California investigators are studying what happens throughout the life spans of mice in whom immune responses to their own tissues were induced immediately after birth.

Learning and Age

Scientists at the Duke University Center for the Study of Aging and Human Development have found that the deficit in the acquisition of information by the elderly is not as great as has been generally believed. Their studies show that much of the apparent deficit is due to failure of the elderly to respond well in the testing situation because of excessive anxiety.

The Duke scientists broke the behavior of the test subjects down into two processes. The first was the process of acquisition of information. The second was performance in using this information in response to some stimulus.

It was in the second, or performance, aspect of the total process that the older people seemed to be hampered. When the investigator asked subjects older than 60 years and subjects less than 50 years old to learn lists of words flashed on a screen at intervals of four seconds, he found that the younger subjects did better. However, at eight-second intervals the older subjects showed a dramatic improvement, while the performance of the younger persons improved only slightly.

It was especially noteworthy that the improvement in scores of the older subjects was attributable to reduction in errors of omission, not of commission. This was an indication that the difference in ability manifested in the short-interval test lay in the failure of the older persons to respond, not in their reduced ability to acquire information.

It was of further significance that when they were given eight seconds in which to respond, the older subjects actually responded within four seconds just as the younger persons did. In other words with the pressure of time removed as a factor in the process, the older subjects learned almost as well and responded just as rapidly as did their younger counterparts in the test.

There was also physiological evidence that the older subjects experienced more anxiety than the younger persons. The level of free fatty acids in the blood rises with anxiety. Increases indicative of anxiety were found in both young and old subjects but were greater in the elderly.

The investigator who conducted this research believes that because of the increased stress they are subjected to in the learning process, the older people may subconsciously disengage themselves from the task of learning.

Self-Evaluation of Disease

Findings indicating that older people frequently do not rate their own health realistically have emerged from a study of about 260 persons that is being conducted by investigators from the Duke University Center for the Study of Aging and Human Development.

The persons in the study are examined periodically by means of very detailed medical, physiologic, psychologic, and laboratory examinations. Information is also obtained about their socioeconomic status. The study, therefore, should admit of determinations about the interrelationships of the medical, psychologic, and social aspects of the patients' lives.

The finding on the reliability of self-evaluation of health emerged from the longitudinal data of the study. Original observations indicated that there was congruity between self-assessment of health and the medical evaluation of physical status in 65 percent of the study subjects. Where there was incongruity between self-assessment and medical evaluation, it was found that the proportions of pessimists and optimists were about equal. In those subjects who were considered to be in good health, 31 percent were health pessimists; in those with poor health, 44 percent were health optimists. In any event, about one-third of the elderly persons in this study could not be relied upon to give an accurate assessment of their own health status.

The Duke investigator who reported the finding said that it is believed that both the optimist and the pessimist are to be accounted medical problems requiring special attention, and urged caution in interpreting the findings on self-assessment of health because of the existence of psychologic-social-economic factors affecting it.

Institutionalization and Stress

Sudden changes in the environment of older persons, such as removal from one institution to another, have been shown to be accompanied by a substantial increase in mortality. An investigator at the University of Chicago is examining the nature of stress associated with institutionalization.

The study focuses on a group of elderly persons who are scheduled to undergo an environmental change; in this case, to enter homes for the aged. They are being studied prior to and after institutionalization. The investigator is examining a series of psychologic variables that are related to the ability of aged individuals to cope with prolonged stress. Some of the factors that are taken into account are self-confidence, reactions to an anticipated threat, physical status, and the presence or absence of hope.

The assessment of adaptation will include consideration of the mortality rate in the first year of institutionalization, the number of psychotic individuals, measurement of satisfaction and self-image, and both the types and patterns of interpersonal relations.

Problems of Retirement

The Aging Program of the Institute, recognizing that research on retirement has direct significance for both problems of adult health and the economic and cultural well-being of the Nation, is sponsoring an examination of ways in which to explore the social and psychologic processes of retirement—including its determinants and its consequences.

The new endeavor was initiated by a first conference held in December 1966. This general conference will be followed by a series of workshops at three-monthly intervals, covering sub-areas of the larger field. Conferences may result in publication of monographs that will be distributed throughout the academic community, as one means of stimulating research.

The Institute staff will be assisted by a small consultant group which will participate in planning the agenda and selecting the participants for the series of working conferences and in coordinating the information that results from them.

These activities result from recognition of a gap in our knowledge. Studies in development tend to cluster around critical periods, periods during which

dramatic shifts take place in the environment and striking changes occur in the individual. One such period is adolescence. But for the period under consideration we do not yet have a name—a reflection of past lack of interest and an omission which predestines inattention. The period of concern is that which leads away from productive adult status, as adolescence leads into it.

During this period, as in the earlier counterpart, major shifts in the life pattern of the individual take place at all biologic and social levels. The individual experiences altered appearance, decline in sensory-motor efficiency, reduction in stamina and endurance, and accumulation of ailments. The climateric is a relevant factor, though it is less synonomous with this period than puberty is with adolescence.

Perhaps, though, the most consistent forces brought to bear at this stage of life are socio-economic. Though cessation of employment, whether a paid job or raising a family, is only one event in this developmental period, it is an important one. There is some advantage in focusing on just one such facet when approaching a complex subject. That is particularly true when little is known about the causative factors and their interaction, and when there is reason to expect that the relationships among them may change. For example, the climacteric and retirement are coming closer together in time, while retirement and expectation of death move farther apart—and the evidence we have regarding the relationship of health to retirement is conflicting in any event.

The social questions inherent in retirement and the gap in information about development have come together to define a task for the Aging Program—to study that period in human development in which a person leaves or is severed from the major work of his adult years. An understanding of the biologic, psychologic, and social forces that underlie development and retrogression during this period are the crux of the problem, if we are to achieve the fullest potential in intellectual capacity, social adaptability, and productive longevity.

Intramural Program.—The intramural research program of the Aging Program, which offers a focus for mounting a planned attack on problems in the field, is concentrated in the Gerontology Branch, located at the Baltimore City Hospitals.

Funds were appropriated in 1963 for the construction of a Gerontology Research Building at the Batlimore City Hospitals. The new facility, which will contain about 90,000 square feet of laboratory space, is scheduled for completion in October 1967.

Its anticipated program will not only greatly increase the Institute's capabilities in intramural gerontologic research, which is the principal purpose of the new facility, but it will also make additional contributions in the application of research results to practical problems of aging through collaborative programs. The facility is also designed to serve as a regional gerontological center, housing research programs on aging conducted by the Baltimore City Hospitals and by investigators from the Johns Hopkins University, and the University of Maryland, among others. Members of the staff will also be making a contribution to the training of other researchers through participation in a training program conducted by the Department of Physiology of the University of Maryland.

In order to explore all aspects of aging, the program of the Gerontology Branch is organized under three broad headings. They are:

Studies on Basic Biologic and Cellular Functions
Studies on the Physiologic Performance of the
Total Individual and on Specific Organ Systems
Studies on Behavioral and Social Characteristics

Among specific significant contributions that the Branch has made since the inception of its work have been additions to our knowledge about systematic changes in physiologic functions with age. For example, a gradual decrement of kidney function with age has been found in normal human subjects. This has now been shown to be the product of a gradual loss of functioning units from the kidney, units which cannot be replaced in the adult. Similarly, a reduction in muscle strength with increasing age was shown to be associated with a gradual loss of muscle fibers. The fall in basal oxygen consumption with age has been demonstrated to be dependent on the loss of tissue and cells in older individuals and not on a slowing in cellular metabolism. These findings, and others, made it evident that one of the key problems in this field is to understand the factors involved in cell death.

In consequence of this understanding, the research program was expanded to include studies of cellular processes, such as studies of different enzymes that

maintain the life of a cell. One thing that was found in these studies was that the pattern of age changes differed among differing enzymes. Succinoxidase, which is involved in energy production in cells, manifests a significant age decrement in heart muscle. This decrement could not be explained on the basis of cell loss alone, because such cells as remained in old hearts also showed a reduction in enzyme activity and in the ability to generate energy. Further experiments indicated that the mitochondria, the cellular elements that contain the enzymes involved in energy generation, were decreased in number in old cells. These results, in their turn, led on to investigations of the mechanisms involved in the transfer of information from the genetic material of the cell to the cellular elements and enzymes that carry on the cell's work.

These and other findings have led to a number of possible hypotheses about biologic and cellular mechanisms of aging, susceptible of testing in the laboratory. Work in these fields aimed at the elucidation of these matters continues.

Some recent findings emerging from the intramural program are also of interest and will be reviewed here briefly under separate headings.

Enviromental Effects of Aging

Although most scientists feel that the maximum life span of an organism is genetically determined, that feeling does not obviate an insistence on the proposition that environment has a considerable influence on actual life span.

Gerontology Branch investigations have used rotifers in order to explore the relative effects of heredity and environment of the life span. These tiny organisms are about 1/50th of an inch long and have a normal life span of about 20 days.

Like other living organisms, the rotifer develops through periods of infancy, growth, and aging, and thereby present the researchers with an opportunity to study what happens over the whole lifetime of an organism in a shortened period of time.

What the NICHD biologists found, in fact, was that if they altered the environment of the rotifer they could more than double its normal life span. It was notable, however, that one kind of change affected the rotifers at one stage of life, while another affected a different stage.

The investigators observed that lowering the level of nutrition increased the rotifer's life span by stretching out its period of growth and development. Restriction of the rotifer's diet greatly increased its number of egg-producing days but did not affect the post-egg-producing period, which remained constant no matter what the diet.

By contrast, reducing the temperature of the water in which the organisms live did affect the post-egg-producing period. A reduction of 10 degrees Centigrade in water temperature increased the organism's total life span by lengthening their brief equivalent of the "senior years," but it had no effect on the growth period.

These findings, in the view of the investigators, suggest the possibility of delaying age without affecting the period of growth and development, by slowing down the processes of the later years of life. They demonstrate also the extent to which environmental influences may modify the life spans of some species of animals and, thus, indicate that it may be possible to increase longevity through manipulation of the surroundings.

Diabetes in Old Age

One major problem for the gerontologist is his confrontation with the need to make distinctions between the physiologic changes in the human system caused by advancing age and those caused by diseases of the same systems with advancing age.

A specific example is posed by diabetes mellitus. In a young individual the presence of an excessively high level of blood sugar following the ingestion of sugar is evidence that the individual has diabetes mellitus. In recent years, however, it has been noted that if diagnostic levels based on the norms for younger people are used, then almost 50 percent of the people who are more than 40 years old must be said to have diabetes mellitus.

In order to help study this problem, scientists at the Gerontology Branch have developed a new technique for the precise control of blood sugar levels in humans. Normally, blood sugar levels are controlled by the body's insulin response to sugar. All sugars that the body takes in are broken down to the simple sugar, glucose, and then converted, by the action of insulin, to glycogen. The glycogen is then stored, principally in the liver, for future use. The new

control technique is based on an externally applied system that overrides the body's own control mechanisms and allows the external regulation of blood sugar levels.

Using this technique, the researchers have gained a greater understanding of the body's response to glucose. They have noted that young adults require about twice as much glucose as do older subjects to produce comparable blood sugar levels. The investigators hope that extensions of these studies will increase our insight into the relationship of diabetes and old age. Present diagnostic standards and diabetic therapy in older patients are based on an inadequate understanding of the impact of age on the body's response to sugar.

Research Training.—One thing that is quite clear is that one of the great handicaps to the development of large-scale aging research programs is the shortage of investigators.

There are a number of problems which face the effort to improve this situation. Young scientists are no more immune to career considerations than are other professionals, and the absence of clear career ladders that besets a new and non-traditional field must be taken into account in explanation of part of this shortage.

The Aging Program of the Institute is placing emphasis on the development of university-based training programs. The training programs, which began with an expenditure of $.2 million in the 1963 Fiscal Year, had expanded to 16 programs costing $1.3 million in the 1966 Fiscal Year.

The philosophy underlying what might be termed the recruitment effort has been to support the training of people in the various disciplines—from biochemistry to sociology—while directing their attention to the problems within those disciplines that are relevant to aging research and aging problems.

In order to provide the kind of communication that is particularly useful in this type of activity, the Aging Program sponsored a Conference of Training Grant Directors in October 1966. The Training Grant Directors, and members of the NICHD Aging Program Staff, participated in this Conference. Among the topics discussed were the organization of training programs, the development of curricula, and the relationship of training and research. The meeting provided a useful base for further development of such training activities.

The Aging Program has also contracted with the Gerontological Society for a study on the needs for training in the various disciplines that underlie the research effort in aging. The report on the findings of this study is expected to be available in June 1967.

Aging Information Center.—The Aging Information Center is one of several centers in various fields currently under development at the Institute. The objective of each center is to give prompt visibility to current work in a field of research. The investigator, with such information available to him, is in a position to move ahead with his work in the confidence that he has not missed information that would help him, and that he is not duplicating any work that has already been done elsewhere.

The workers in the Aging Information Center will scan the world's literature, identify articles on aging, abstract those articles, and store the abstracts in a computerized system. The abstracts will be published periodically in journals developed for that purpose.

The existence of a computerized system for the storage of the abstracts will make possible the rapid performance of many special bibliographic services. Individual investigators and institutions can ask that the system be searched for all abstracts that bear on any of a wide variety of topics.

Social Security Administration

OBJECTIVE

The Social Security Administration is responsible for administering the social security program which provides old-age, survivors, and disability insurance protection for over 90 percent of the workers and their families in the United States. It also provides hospital insurance protection for virtually all individuals in the United States who are age 65 or older, as well as supplementary medical insurance coverage for those age 65 or over who elect to come under the program.

BENEFITS TO OLDER PERSONS

Cash Benefits.—Monthly benefits are paid: (1) To insured workers between the ages of 62 and 72 who have substantially retired from gainful employment

and beginning at age 72 without regard to work status; benefits are also paid to wives of beneficiaries at or after age 62 and to widows of insured workers when they reach age 60. Children of retired, deceased, or disabled workers are also eligible for benefits when they are under age 18, and after age 18 if they have a severe disability which began before that age and which has made it impossible for them to work and support themselves. For those children continuing to attend school at age 18 and above, monthly benefits are payable up to age 22. Benefits are paid to mothers (irrespective of their age) when they have such children in their care, except for the students age 18 and over; (2) to insured workers up to 65 years of age who have worked a specified period of time in covered employment and have a medically determinable disability which can be expected to last for a continuous period of not less than 12 calendar months and so severe that it prevents them from engaging in any substantial gainful activity; and (3) to certain individuals age 72 and over who are not insured under the social security program. Legislation was enacted in the second session of the 89th Congress (P.L. 89–368) to provide for payment of monthly benefits to these individuals. The payments under the new provision were effective for the month of October 1966. The cost of making the payments to people who have less than three quarters of coverage will be met from the general funds of the Treasury.

Of the 23 million beneficiaries receiving monthly old-age, survivors, and disability insurance benefits at the end of December 1966, nearly 18 million were age 62 or over. About 89 percent of all persons now 65 and over are either receiving old-age and survivors insurance benefits or would be eligible for benefits on retirement. This proportion will grow until practically all aged persons are protected. The number of disabled workers and their dependents receiving benefits at the end of December 1966 totaled 2 million.

Monthly benefits which were being paid at the end of June 1966 for retired workers without dependents averaged $80; for a retired worker and his aged wife, the average was $142; and for an aged widow only, $74. For families with benefits computed on the basis of earnings after 1950, the averages were higher. Among these families the average benefits being paid at the end of June 1966 were $88 for a retired worker with no dependents, $149 for a retired worker and his aged wife, and $84 for an aged widow only.

These average benefits are expected to increase over time, since the percentage of benefits based on earnings after 1950 is higher for current awards than for all benefits currently being paid. Also, the maximum earnings base which can be used in calculation of benefits has been increased from $4800 to $6600 effective January 1, 1966, as a result of the 1965 amendments.

Health Insurance Benefits.—Beginning July 1, 1966, nearly all of the 19 million persons aged 65 and over in the United States were afforded basic protection against the costs of inpatient hospital services, outpatient diagnostic services, and post-hospital home health services. Protection against the costs of post-hospital extended-care facilities will be afforded beginning January 1, 1967.

During fiscal year 1966, the aged population was given an opportunity to enroll in the supplementary medical insurance program, which covers most other medical expenses, excluding drugs, above a $50 yearly deductible amount. This program was effective July 1, 1966. An estimated 17.3 million individuals age 65 and over were enrolled in this program on July 1, 1966. Monthly premiums of $3 per month will be paid by the enrollees with a matching amount being paid from general revenues of the Treasury.

SERVICES TO AGED INDIVIDUALS AND TO COMMUNITY GROUPS

The social security district offices give information to the public and answer inquiries about the benefits available to those who meet the conditions specified under the insurance provisions of the Social Security Act. Old-age, survivors, and disability insurance claims for benefits are received, developed and initially adjudicated in the district offices. Help is given in securing the factual information needed to determine eligibility for benefits and persons filing claims are advised as to their rights. For those adult beneficiaries determined by SSA to be incapable of management of their benefit funds, usually based on the evidence of a physician's statement, a person other than the beneficiary is selected to receive the checks, and is held accountable for their use in the best interests of the beneficiary. District offices perform various post-adjudicative functions in con-

nection with termination, suspension, reinstatement, and adjustment of benefit payments to safeguard the trust funds against improper payment or fraud and to provide necessary services for beneficiaries. Local communities are served by over 626 district offices and approximately 3500 branch offices, service centers, resident stations, and contact stations.

District offices keep current information about community resources and make referrals to meet the service needs of persons seeking help to other agencies when appropriate. The district office manager and staff also participate with local groups in planning for community services.

The Social Security Administration cooperates in many with other other Federal, State, and local programs, especially with community agencies which can offer services not provided by the social security insurance programs.

The modes of cooperative endeavors between the SSA and other agencies include both the experimental and the continuing efforts to meet selected problems and needs. The first is illustrated by joint projects of PHS and SSA wherein applicants to SSA in a few selected communities are offered a health counseling service by a PHS counselor separate from the district office operations, to help the aged person find health resources and maintenance in the event he has none or is neglectful of his health. In other communities social security is not directly involved, but with a fully developed comprehensive health service program available to a group such as found in a housing center project, the Social Security Administration can make immediate referrals of persons seeking health care with assurance it can be provided. In such a project it is essential that SSA staff keep fully informed on the nature of the project and what services are available to people who are referred to it.

Social Security joins with other responsible organizations of the community in gathering adequate information on the numbers of aged, disabled, and dependent children of survivors, for purposes of community planning for the continued development of health, vocational, and welfare services. With the advent of Medicare and medicaid there has been increased interest in community analysis of resources such as hospitals, extended care facilities, home care, and other health services. At the same time there is need for corollary information on the numbers of SSA beneficiaries in different categories, and data which might give clues to both incidence and trends in critical problems of people. With widespread gaps in health resources such as nursing services, and with the need for community planning recognized through passage of a new grant program to State and local communities for planning, SSA is an active member of the team in many areas.

The following are examples of SSA cooperation and collaboration with other agencies toward the objectives of having more services available to beneficiaries and all others in the community who need the services:

1. At the Federal level more services are being developed through interagency planning committees directed by:

A. Department of Agriculture for rural health projects in selected areas.

B. Public Health Service for health maintenance projects for the aged.

C. Welfare Administration for procedures to obtain information on needs of child survivors of beneficiaries.

D. Welfare Administration for development of protective services projects to meet the needs of incapable aged beneficiaries.

E. HUD for development of experimental information and service neighborhood centers.

F. VRA for planning grants to expand training for the health professions and allied personnel.

G. PHS on programs for the education of agency personnel in local communities on potentials in home care and combined health services and in communities without facilities for such programs.

2. At the State level the assistance to State health departments to fulfill Medicare requirements and to promote full potential for care of the aged in institutions, outpatient, and home care models with:

A. Participation in experimental training programs for community service personnel on the problems and needs of the aged or chronically ill.

B. Consultation to State personnel, e.g. when used for planning and promotion of health services as related to medical care.

3. At the local level inter-agency community planning and development of resources such as:

A. Surveys and analysis of health and welfare facilities and services.

B. Collaboration on information and referral centers, providing a contact service for persons having questions or concern about SSA benefits.

C. Experimental centers of information or service under special arrangements, such as in the Federal Office Building, to help the public obtain information on Federal services. One of these is functioning in Atlanta and half of the public inquiries in the Federal Office Building are related to SSA.

D. Demonstrations of vocational training to provide the unskilled and lesser employed person in certain rural deprived areas selected in conjunction with regional and State staff.

E. Close cooperation with welfare and service agencies providing special help to handicapped or other groups such as the mentally retarded.

RESEARCH ON ECONOMIC SECURITY FOR THE AGED

The Social Security Administration research and statistical program provides information derived from the operations of the Social Security Administration system, from population surveys and from studies of related public and private income maintenance programs that is useful for continuous evaluation of the effectiveness of the social security program in providing economic security for the aged, including protection against the costs of hospital and medical care. Data are developed and published regularly in the *Social Security Bulletin* and its *Annual Statistical Supplement*, in special published reports and in various other ways to meet user requests. Indicative of the types of information made available and of interest to officials and groups planning programs for the aged are: continuously reported data on claims and benefit payments to retired workers and their dependents; the findings of surveys of the aged population, including OASDI beneficiaries, providing information as to the level of security the social security benefits provide (information obtained includes total and sources of income of individuals and families, level and types of assets owned, special demands on income such as medical expenditures, etc.); special studies that show the changing share of the total national output going to the aged, what measures of income adequacy are most appropriate and meaningful, the relations between individual and family income over the life cycle; continuing statistical series that are concerned with the totality of public and private income maintenance protections and the relative weight of the social security program in that totality; research to measure the impacts on both public and private health and medical care; identify and define gaps and unmet needs under the health insurance program, and examine and evaluate the economic consequences of the health insurance program. Social Security Administration research draws heavily upon basic data in the social security system, data from the population survey program, and upon data from Census, BLS and other statistical sources.

VOCATIONAL REHABILITATION ADMINISTRATION

The objective of the Aging program of Vocational Rehabilitation Administration is to rehabilitate as many older handicapped persons as possible into gainful employment, and to provide services enabling those who cannot be employed to reach their greatest potential. This is accomplished through activities of the State-Federal rehabilitation program administered by the Vocational Rehabilitation Administration.

National Health Survey estimates indicate that 7.8 million persons (not retired) aged 45 and over have one or more chronic conditions partially or totally limiting their major ability.[1]

The Vocational Rehabilitation Administration calculates that 1.8 million of them—including 130,000 persons 65 years of age or older—would need vocational rehabilitation services in order to return to work.

The remaining 5.2 million cannot be rehabilitated into employment, but many could, in varying degrees, be returned to self care and independence through appropriate services.

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[1] Chronic conditions and activity limitation—U.S.—July 1961–June 1963, Series 10, No. 17—May 1965, U.S. D/HEW.

Of the 154,279 persons rehabilitated in fiscal year 1966, there were 41,484 aged 45 and beyond, over one-fourth of the total number of individuals rehabilitated in all disability categories.

PROGRESS IN REHABILITATION OF THE AGING DISABLED

As a result of modern rehabilitation services, there are many thousands of handicapped middle-aged and older persons employed in every occupation performing jobs as efficiently and reliably as workers who have no handicap.

Since 1945, when 7,344 disabled persons 45 years of age and older were rehabilitated, there has been a steady increase in the number of aging handicapped individuals rehabilitated into employment. For example, in 1964, 34,019 persons were rehabilitated while in 1965 the number was 36,656. In 1966, 41,484 persons were rehabilitated over 5 times the 1945 figure.

It is estimated that a total of 49,800 persons aged 45 and beyond will be rehabilitated during fiscal year 1967 and a possible 56,000 in 1968.

State vocational rehabilitation agencies: Rehabilitated persons 45 years of age or over at acceptance, fiscal years 1964–68

Fiscal year	All rehabilitants	45 years of age and over
1964	119,708	34,019
1965	134,859	36,656
1966	154,279	41,484
1967	190,000	49,800
1968	218,500	56,000

RESEARCH AND DEMONSTRATION PROJECTS SERVING THE AGED

A wide diversity of problems is found among older disabled people. In order to obtain more knowledge about these problems, the Vocational Rehabilitation Administration is helping to support research and demonstration projects relating to this older group. Since 1954, the Office has provided financial assistance amounting to over $7 million for these projects. Usually, the sponsors of such projects contribute an additional dollar for every two dollars of Federal grant funds, and to date grantees have invested nearly $3 million of their own funds in these research and demonstration activities.

In 1964, the Vocational Rehabilitation Administration supported projects with grants amounting to $1,511,000. All of these projects were developing new methods and techniques for dealing with the problems of disability among older disabled individuals. For example, a project in New York City pioneered in demonstrating that disabled older workers could be retrained and placed in employment. 197 handicapped men over 60 years of age were placed in competitive industrial employment. The oldest individual placed was over 80. The results of this project were so successful that similar projects were established in Kansas City and St. Louis, Missouri; St. Paul and Mankato, Minnesota; Milwaukee, Wisconsin; Miami, Florida; Gadsden, Alabama; Dallas, Texas; Philadelphia, Pennsylvania; the Virgin Islands and in 1964, a project was approved for operation in Chicago, Illinois. On two occasions representatives of these projects attended conferences in New York City at which the training and placing of older handicapped workers in employment was discussed.

Another project launched in June 1962, a 5-year program, is designed to evaluate the response to regular employment of selected disabled men and women over 60 years of age in Coney Island, New York.

A number of projects are seeking to assist older people confined to institutions and nursing homes to become as self-sufficient as possible. For some, this would mean a resumption of a normal place in community life.

In the State of Washington a VRA Sponsored project to rehabilitate the chronically ill confined to nursing homes was very succesful. An elderly woman unable to respond, walk or feed herself was committed by her family to a mental hospital and remained for 18 months. She was released to a nursing home and after six weeks of intensive treatment by the staff was able to respond, feed herself, and walk. She was subsequently returned home and her family was delighted and amazed at her progress.

The University of Michigan and the Illinois Public Aid Commission developed special staff training techniques and rehabilitation methods applicable in public and private nursing homes.

At highland View Hospital, Cleveland, Ohio, a project successfully demonstrated that rehabilitation is possible for long-term hospital cases disabled by severe chronic diseases.

All of the research and demonstration projects have a common goal—finding new techniques and methods for restoring maximum functional or earning capacity to older disabled people.

Training

Since it is anticipated that a higher proportion of older disabled persons will require rehabilitation services, more of the training resources of the Vocational Rehabilitation Administration are being devoted to increasing the proficiency of rehabilitation personnel in relation to the older disabled person. The Administration is supporting special institutes in geriatric rehabilitation in a number of our universities.

For example, the Department of Physical Medicine and Rehabilitation of the New York Medical College Metropolitan Hospital Center conducted a two-week course on the principles and practices of geriatric rehabilitation for registered nurses, occupational therapists, physical therapists and social workers.

The Vocational Rehabilitation Administration cooperated with Northeastern University, Boston, Massachusetts in sponsoring a short-term course on the Older Disabled Worker which was very successful.

In 1964, the Vocational Rehabilitation Administration cooperated in sponsoring short-term training courses with the University of Denver, Florida Institute for Continuing University Studies, University of Michigan and the West Virginia Division of Vocational Rehabilitation.

In the past, workshops have been held in California, Arizona, Oregon, Utah, Texas, Mississippi and West Virginia in order to bring together community agencies for a cooperative attack on problems of service to the aging. Future plans call for such workshops to be held in additional States for this same purpose.

ACCOMPLISHMENTS

Research

Although many economists and labor experts agree that the older worker has valuable skills and talents which can be utilized, unfortunately many employers and a large portion of the general public are not convinced of his ability, much less the ability of the older handicapped worker, to produce in competitive employment.

The Vocational Rehabilitation Administration is attempting to counteract this point of view through research projects designed to present facts on the older disabled worker's productivity. For example, projects have been conducted in Florida, Colorado, Massachusetts, Michigan, Texas and New York geared to train and place the older handicapped worker into competitive industrial employment.

The New York project previously referred to, a 5-year project, is evaluating results of a community-operated vocational rehabilitation program. Results of these studies, plus results obtained from other VRA supported projects, will provide tangible evidence regarding the adjustment and performance of the older handicapped worker on the job.

A number of research and demonstration projects are designed to assist older people confined to nursing homes to become as self-sufficient as possible and to train nursing home personnel in modern rehabilitation techniques that can be applied to older persons under their care.

Jobs for the Blind

The Vocational Rehabilitation Administration puts forth sustained efforts to open greater job opportunities for the blind including the expansion of vending stand opportunities under the Randolph-Sheppard Act. The majority of blind persons rehabilitated are over 45 years of age, and over half of the vending stand operators fall into this age group.

Jobs for the Deaf

As the inroads of automation have their impact upon the employment of the large numbers of older deaf workers in skilled and semi-skilled occupations, efforts should be increased to emphasize retraining and re-employment.

Social Security Disability Applicants

The Social Security Disability Insurance program serves as an important referral source of older disabled persons for State vocational rehabilitation services. Over the past several years, more than one-half million persons have applied annually for disability benefits and have been considered for rehabilitation services. The number of disabled workers receiving social security disability benefits reached 1 million in 1966. In recent years, the median age of such beneficiaries has been 57. To make it possible for more of these persons to receive State vocational rehabilitation services, the 1965 Amendments to the Social Security Act authorized the use of OASDI trust funds to pay the cost of such services to selected disability beneficiaries. The money is to be used in such a way that the saving from the amount of benefits that would otherwise have to be paid and the contributions to the trust funds paid on the earnings of beneficiaries who return to work would exceed, or at least equal the money paid from trust funds for rehabilitation costs. An estimated $15 million will be available from trust funds in fiscal year 1967 during which time it is expected that all the States will be participating in the program.

FUTURE PLANS

Administration on Aging

State and local communities will be greatly assisted in their efforts to provide services for the aging through provisions of the Vocational Rehabilitation Amendments of 1965 and the Older Americans Act of 1965. To aid in implementing these provisions, and to insure that full consideration will be given to the rehabilitation needs of the aging, a joint communication from the Commissioner of Vocational Rehabilitation and the Commissioner on Aging was issued to State Vocational Rehabilitation Agencies and State Commissions on Aging urging closer cooperation and collaboration in planning program activities and services for the aging.

Research and Demonstration

In order to make progress in rehabilitating older disabled people it is necessary to have factual data. Such data is obtained primarily from research through which methods and procedures for various types of rehabilitation services are discovered, developed, and adapted for use.

It is planned to continue emphasis on research projects and conduct demonstrations throughout the country which will illustrate the techniques or findings of research projects. Such demonstrations will serve to illustrate that with proper evaluation, training, and placement many older people can return to work, or with other assistance achieve greater independence.

Training of Personnel

There is an urgent need to orient hospital, nursing home and other institutional personnel in modern methods of rehabilitative care and techniques. There is also the need to stimulate and expand training programs in rehabilitation for physicans, occupational therapists, physical therapists, rehabilitation counselors, speech and hearing therapists, and other specialists concerned with rehabilitation of the disabled.

Community Resources

It is of the utmost importance to establish services in the community for post-institutional care of the aged who are ill, services to sustain disabled individuals after restorative medical care and prevent or reduce the need for institutionalizing persons who could be maintained in their homes. There is also a need to promote job opportunities for the aged disabled among local employers, to establish recreation programs, friendly visitor programs and other projects.

As our aging population increases, the demand for various types of services becomes greater, necessitating plans for expanded program operations and increased financial assistance to make program expansion possible.

The Vocational Rehabilitation Administration will continue to put forth sustained efforts to provide improved services for more aging disabled people in order that they may be able to be vocationally rehabilitated and/or help themselves realize their full potential.

Welfare Administration

Programs and Objectives

The Bureau of Family Services of the Welfare Administration administers public assistance grants to States for nearly 3 million older people who are aged, blind, or disabled. In addition, the Bureau administers grants to States for medical assistance programs serving these public assistance recipients and other medically needy people.

Public assistance provides three kinds of help for needy older people: cash to buy food, clothing, shelter and other necessities; payments to hospitals, physicians, and others for medical care; and social services to help them achieve as much personal and economic independence as possible.

Old-Age Assistance (OAA)

This program served about 2,097,000 persons 65 and over in September 1966. This is a marked decline from the all-time high of 2,810,000 in September 1950 despite the steady increase in the number of aged people in our population. This is due to the rapid increase in the number of persons receiving Old Age, Survivors, and Disability Insurance (OASDI).

It has been estimated that in FY 1968—for the first time since 1940—the caseload figure will fall below the 2 million mark.

All 50 States, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands have OAA programs. The national average in September 1966 was about $67 for maintenance plus about $7 for medical vendor payments.

According to a 1965 study, the median age of old-age assistance recipients was nearly 77 years. This was an increase of about 2 years over the median age in 1953. The proportion of those living alone in their own homes increased from 27 percent in 1953 to 35 percent in 1965. During the same period, however, the proportion requiring help from others rose from 18 percent to 27 percent, including a rise from 5 percent to 9 percent for those living in institutions. In 1965, recipients were older, less mobile, and were increasingly the victims of chronic illness.

Medical Assistance for the Aged (MAA)

This program pays for basic medical care for some 52,000 people over age 65 who have enough income for their basic living costs but need help with medical expenses. The average monthly payment in September 1966 was $122. Hospital care and nursing home care costs accounted for 92 percent of total MAA expenditures. The remaining 8 percent covered physicians' care, prescribed drugs, and other services.

In December 1965, 47 States and areas operated MAA programs, serving 280,000 people, while in September 1966, the MAA program was in effect in only 22 States, Guam, and the District of Columbia. This decrease reflects the shift many States made to the broader Medical Assistance Program under title XIX of the Social Security Act, commented on below.

The 1965 Social Security Amendments, which provided for hospital and voluntary medical insurance for persons over 65 under the Social Security Program, reduced the need for the MAA program. The need will be further reduced as States establish a single Medical Assistance Program (also provided for in the 1965 Amendments) to serve the medically indigent. In States that do not yet have the new Medical Assistance Program, the Medical Assistance for the Aged Program is still needed to cover medical expenses including payments or deductibles and premiums which are not provided for by Medicare.

Medical Assistance Program (MAP)

This program began January 1, 1966, and by 1970 will be the only way States can receive Federal funds for vendor payments for medical care for public assistance recipients. To establish MAP, a State must provide high-quality medical and remedial care to all persons receiving public assistance. By 1975, the program must be extended to children and adults who do not qualify for public assistance but do need help with medical expenses.

On December 1, 1966, twenty-eight jurisdictions were operating the Medical Assistance Program: California, Connecticut, Delaware, Hawaii, Idaho, Illinois, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Nebraska, New York, New Mexico, North Dakota, Ohio, Oklahoma, Pennsylvania, Puerto Rico, Rhode Island, Utah, Vermont, Virgin Islands, Washington, West Virginia, and Wisconsin. All of these States except Ohio had formerly operated MAA programs.

ACCOMPLISHMENTS

Increased Payments

A new Federal matching formula, effective January 1, 1966, makes it possible for States—without any increase in State funds—to add an average of $2.50 per month to the payment of each adult receiving oldage assistance (OAA).

To encourage dependent people who could earn at least a part of the money they need, after October 1, 1965, States could permit OAA recipients to keep earnings of up to $50 a month without having their public assistance payments reduced, in addition to an exemption of up to $5 a month from any source. The provision relating to the $50 earned income exemption was in effect in 12 States by the end of December 1966; 11 States were providing for exemptions under the $5 provision.

Social Services

Sustained effort was made to help States provide the improved social services which, under the 1962 public welfare amendments, entitled them to receive 75 percent Federal funds instead of 50 percent as formerly. By January 1, 1966, 41 jurisdictions were providing improved social services in the programs for the aged, blind, and disabled. Reviews of State operations indicate that some States are providing services to a significant extent, the reviews also reflect variations in the tooling-up process for statewide provision of services and difficulties in providing services because of insufficient staff. The most frequently provided services for the aged relate to securing needed medical care, enlisting help from relatives and friends for planning and protection, and assisting in maintaining safe living conditions in the home.

In the 41 States which have elected to provide the improved social services with 75 percent Federal funds, 15 States and the District of Columbia have established a position or a staff unit in the State department of public welfare to develop social services for older adults. They are Arkansas, California, Colorado, Florida, Illinois, Kansas, Maine, Minnesota, Nevada, New Mexico, New York, Pennsylvania, Rhode Island, Utah and Wisconsin.

Six States that have not elected to provide the improved social services in the adult programs have appointed specialists on social services to the aged. These States are Maryland, Mississippi, North Carolina, Oklahoma, Texas, and Washington.

Progress was made in responding to State requests for guides, standards, and interpretive materials on social services. Technical assistance was provided to States as requested in the development and extension of homemaker services, legal services for the poor, and many other social services areas.

Institutional Care

The 1965 Amendments to the Social Security Act also made possible, for the first time, Federal sharing in payments to needy aged persons in institutions for mental illness and tuberculosis. As of the end of December 1966, 19 jurisdictions

had adopted the provision with respect to institutions for mental illness; 16 jurisdictions had adopted the provision for tuberculosis institutions.

Demonstration Projects

In 1966 there was an increase in the number and variety of State demonstration projects involving the aged, including: several projects to provide homemaker services (Alaska, Kentucky, Mississippi, and South Carolina); legal services (New York); development of a simplified method of determining eligibility in OAA by use of a declaration form (West Virginia, Colorado, California, Maine); protective services (Colorado); and establishment of State specialists on services to the aging (Arkansas, Colorado, Maryland, Mississippi, Nevada).

The North Carolina State Board of Public Welfare, in cooperation with Duke University Medical Center, is conducting a project to demonstrate the value of psychiatric services to elderly people. Under the project, members of the psychiatric staff of the University provide training and case consultation to staff in all 100 county departments of public welfare. The unit on services to the aged in the State welfare agency is coordinating the project.

In cooperation with the School of Social Work at the State University of Iowa, a local Department of Public Welfare (Cedar Rapids) is carrying out a demonstration project to provide comprehensive social services to the elderly. The services included are homemaker services, meals on wheels, telephone visitation services, and special social group work services in community nursing homes and homes for the aged.

The Texas State Department of Public Welfare has established a demonstration project to provide comprehensive social services to the elderly in two public housing developments in Dallas and Houston. A team consisting of a supervisor and 3 caseworkers will demonstrate the value of providing a full range of social services to elderly residents.

Improved Staffing and Training

While there has been only a small increase in the number of caseworkers specially equipped to work with older adults, States are providing greater opportunities for staff development. The Bureau of Family Services has produced a film titled "The Later Years of the Woodleys" which deals with the special needs of older clients. This film will be available to all States.

A regional institute on aging was held in August 1966 at the Center for Continuing Education of the University of Oklahoma. Thirty-six public welfare workers and supervisors from Oklahoma, Kansas, Texas, and Colorado participated in this week long institute.

In October 1966, 26 State specialists on aging met in Washington, D.C., to review national trends in the field and to consider significant findings of the Bureau's administrative review on social services affecting the aged, blind, and disabled. Also discussed were standards for social care institutions and new developments in housing legislation.

The greatly increased attention of the States to social services has required intensified consultation and factfinding activities particularly in helping the States to implement the 1962 public welfare amendments.

The Bureau has conducted administrative reviews of social services in all States. The purpose of these reviews was to evaluate State efforts to improve social services for public assistance recipients. Preliminary findings indicate that social services to older people are lagging behind services to families and children.

FUTURE NEEDS

Much remains to be done. State public welfare departments continue to have difficulty in securing adequate appropriations for staff and for training. Staff turnover is high among caseworkers. The level of service provided indicates a great need for caseworkers and supervisory personnel working with the aged

to know more about the biological, medical, and psycho-social components of behavior in the aged.

Some specific future needs:

1. The average monthly money payment must be raised. It varies from a low of $8.60 in Puerto Rico to a high of $105.35 in California. The average (minus vendor payments for medical care) was $66.83 in September 1966.
2. There is a need for comprehensive health care for the aged.
3. More services by homemakers are needed to help older persons who are feeble and ill remain in their own homes.
4. Better housing for the aged is needed to replace homes that are inadequate, unhealthy, or unsafe.
5. Improved social and legal services are needed for all older people who require protective services.
6. More high quality nursing homes are needed. In 1953, older persons in nursing homes comprised only 3.1 percent of the total population 65 and older; in 1965 the figure was 6.6 percent.
7. Social care facilities are needed for persons requiring group care, but not in medical facilities.
8. There is a need for the development of more alternate care arrangements for aged persons now confined to institutions for mental disease. They deserve care that is appropriate to their personal needs and their diagnosed physical and mental conditions.

FUTURE PLANS

Standards and Guide Materials

Additional guide materials on methods of working with the elderly, including older blind and disabled adults, are being prepared for use by States.

Staff Development

Increased emphasis will be given to the development of regional institutes on services to older adults in the public assistance program. Faculty members from schools of social work will be employed to work with key staff in State departments of public welfare.

Model Demonstration Projects

It is expected that a number of model demonstration projects relating to aging will be financed in selected local departments of public welfare. The projects, each of several years duration, will demonstrate how public welfare agencies can improve social services to the aged. The projects will concentrate on the use of protective services for the aged, neighborhood service centers, foster family homes, and social services in public housing.

Special Services to Older Adults in Metropolitan Areas

There will be increased emphasis on the provision of services through neighborhood units to meet the needs of older adults living in metropolitan areas.

Cooperative Work With Other Agencies

Staff will continue to assist in programs and projects of the Committee on Aging, American Public Welfare Association; Family Service Association of America; the National Council on the Aging; the Committee on Aging of the National Urban League; the Administration on Aging in the Department of Health, Education, and Welfare; and the National Federation on Settlements and Neighborhood Centers.

Medical Assistance Program Plans for the Aged

Additional States will be encouraged and helped to establish medical assistance programs that will benefit not only the needy aged but all people who cannot afford adequate medical care.

Funds for programs on aging

[In thousands—existing legislation]

	1964	1965	1966	1967 estimate	1968 estimate
General fund appropriations:					
Food and Drug Administration (enforcement)	$12,708	$15,206	$18,512	$19,720	$20,522
Office of Education (vocational education, library services, research, supplementary centers and services, community services, adult basic education, and administrative costs)	3,821	17,758	22,140	25,510	27,490
Vocational Rehabilitation Administration:					
Grants to States	24,600	27,001	39,949	60,557	72,520
Research and demonstrations	1,511	846	694	576	609
Training and traineeships	11	18	10	25	25
Total, VRA	26,122	27,865	40,653	61,158	73,154
Public Health Service:					
Bureau of Health Manpower	619	2,128	1,376	8,109	18,359
Bureau of Health Services	49,085	50,990	63,197	68,297	64,378
Bureau of Disease Preventions and Environmental Control	41,842	54,175	59,058	61,773	14,082
National Institutes of Health	3,996	4,764	6,003	8,475	8,570
Total, PHS	95,542	112,057	129,634	146,654	105,398
Welfare Administration:					
Bureau of Family Services:					
Grants to States for Public assistance:					
Age 45 to 65	222,100	252,900	293,700	400,800	447,700
Age 65 and over	1,631,200	1,711,700	1,903,900	1,954,500	1,991,500
Total, WA	1,853,300	1,964,600	2,197,600	2,355,300	2,439,200
Administration on Aging (Grants to States for community planning, services, and training; grants for research, demonstration, and training; and technical consultation services)	545	587	7,341	10,275	18,450
Total, general fund appropriations	1,992,038	2,138,073	2,415,880	2,618,617	2,684,214
Federal old-age and survivors, disability, hospital, and medical insurance trust funds:					
Social Security Administration:					
Disability payments: Age 45 to 64	1,017,000	1,135,000	1,398,000	1,499,000	1,595,000
Retirement/survivors payments:					
Age 45 to 64	1,097,000	1,140,000	1,334,000	1,439,000	1,512,000
Age 65 and over	11,861,000	12,410,000	14,503,000	15,288,000	16,097,000
Hospital insurance payments: Age 65 and over	----------	----------	----------	2,395,000	2,624,000
Supplementary medical insurance payments: Age 65 and over	----------	----------	----------	861,000	1,121,000
Total, insurance trust funds	13,975,000	14,685,000	17,235,000	21,482,000	22,949,000
Total, Department of Health, Education, and Welfare	15,967,038	16,823,073	19,650,880	24,100,617	25,633,214

Juvenile Delinquency

Introduction

The complex problem of juvenile delinquency is of increasing national concern, both because of its monetary cost, estimated at more than $20 billion a year, and because of the inestimable loss to society in the damaged lives of troubled youth. The number of delinquency cases among youngsters between the ages of 10 and 17 has been increasing faster than the number of youth in this age group. Recent studies indicate that one out of five boys in the age range of 10–17 will appear in juvenile court. This is a nationwide average; in some deteriorated urban areas, as many as nine out of ten juveniles have had juvenile court contact.

To attack this crucial problem, a number of units within the Department of Health, Education, and Welfare are seeking new solutions through demonstration and training programs, and are strengthening State and local efforts through consultation and dissemination of current information about successful community experiences.

On the national level, there is an increasing insistence that more positive steps be taken to prevent and control juvenile delinquency. To meet this demand, two reports, by the National Crime Commission and the District of Columbia Crime Commission, have been completed and sent to the President. The reports provide a broad view of the problem of crime and delinquency and outline a series of steps which might be taken to effectively come to grips with the problem. The Department of Health, Education, and Welfare, through its diverse interest in crime and delinquency, and its numerous programs in this area, is in an unique position to develop and implement many of the recommendations of these two groups.

While there are many varied programs and strategies for tackling the problem of delinquency within the Department, there are also many common threads that appear among the attached unit reports. There is a consensus that the key areas of intervention to prevent delinquency are education, youth employment, neighborhood services, courts and corrections, group services, legal services, and youth involvement. Interdepartmental activities emphasizing exchange of ideas and materials, and joint conferences and committees have strengthened and coordinated ongoing programs and new developments.

One of the principal authorizations for Federal stimulation of programs and activities in the field of juvenile delinquency prevention and control, the Juvenile Delinquency and Youth Offenses Act of 1961, as amended, will expire on June 30, 1967. A proposal will be submitted to the Congress for new authorizations to extend and improve the juvenile delinquency and youth development programs.

Individual reports describing the work of the following agencies in the Department are contained in this overview:

1. Welfare Administration:
   a. Children's Bureau—Division of Juvenile Delinquency Services.
   b. Office of Juvenile Delinquency and Youth Development.
2. Public Health Service—National Institute of Mental Health.
3. Office of Education.
4. Vocational Rehabilitation Administration.

1. Welfare Administration

Title V of the Social Security Act places responsibility with the Welfare Administration through the grant-in-aid program to States for child welfare services and consultative and staff services, to safeguard children and young people by preventing or remedying or assisting in the solution of problems which may result in delinquency. In addition, the Welfare Administration is charged with carrying out juvenile delinquency activities under the Act of 1912 creating the Children's Bureau, and the Juvenile Delinquency and Youth Offenses Control Act of 1961.

a. *Juvenile Delinquency Program, Children's Bureau.*—The Children's Bureau was created by Act of Congress in 1912 and initiated studies in the field of juvenile delinquency in 1914. In 1952, subsequent to a Bureau review of procedures and programs on juvenile delinquency, a Juvenile Delinquency Branch was established in the Division of Social Services in 1952, to be followed by the present Division of Juvenile Delinquency Service authorized by the Secretary of Health, Education, and Welfare as the result of a supplemental appropriation by Congress in 1954 to enable an expansion of the Bureau's services in the field of delinquency.

The Division provides technical assistance to public and voluntary agencies and develops standards, guides, and methods relating to various types of services and care for delinquent children. The fields covered include police work with juveniles; court and probation services; institutional care for delinquent children, including training schools, forestry camps, and detention care; legal aspects of delinquency, including legislation; community coordination and planning for the prevention, control, and treatment of delinquency; group work with delinquent children and potential delinquent gangs; and training programs for personnel, professionals, and nonprofessionals working with delinquent youth.

The Bureau, through its Division of Research, has obtained a more precise national picture on the total volume of juvenile delinquency, from 1,800 juvenile court statistical reports utilized as the base of a representative sampling of data of 500 juvenile courts. Juvenile Court Statistics are compiled and released by the Bureau annually. The Division of Social Services, through its expanded grant-in-aid program to States for child welfare services and its consulative services, continued its effort to safeguard children and young people who seemed prone to commit delinquency acts.

Regional child welfare staff consult with citizen groups, public welfare administrators, legislators, and legislative commissions on community need and direct request for technical assistance to the Division of Juvenile Delinquency Service.

The President's interest in crime and delinquency manifest in the Crime Message to Congress in March 1966, and the appointment of a national Commission on Law Enforcement and the Administration of Justice and a similar District of Columbia Commission has created an increased demand for consultation from Staff of Juvenile Delinquency Service as well as temporary assignment of Staff to these two bodies.

In fiscal 1966, 825 consultative field trips were made by the Division staff, and consultation was provided to representatives of 45 foreign countries who visited the Bureau. Consultation and field work were related to such subjects as: legislative review of a Uniform Juvenile Court Act in the United States and a similar review of a proposed Juvenile Court Act of Japan; structuring State services to juveniles; and appellate matters in juvenile cases, based on Standards for Juvenile and Family Courts, issued in 1966, which has been used as legal resource material in juvenile matters before the Supreme Court, copies of the Standards have been furnished to the Court on request and to the American Civil Liberties Union and the National Commission on Law Enforcement and the Administration of Justice. States, Bar Associations, Governor's Commissions and Legislative Commissions sought consultation on every facet of service to delinquent children, from State structure, detention, police methods, training, institutional care, juvenile and family courts and probation services, to aftercare and parole. And, three papers on juvenile courts and the administration of juvenile justice were prepared for the National Crime Commission.

Publications prepared by Division staff on delinquency control and treatment were furnished to the International Association of Youth Magistrates (Paris, France) in June 1966.

A survey of the Youth Service Division of Massachusetts, made at the request of the Governor, which involved total Division staff has been submitted to the Governor's Commission for factual clearance. Other completed surveys in 1966 for services to delinquent youth are Portland, Oregon; Peoria County, Illinois; detention care in Central Missouri; Anne Arbor, Michigan; and Jackson County, Missouri. Continuing surveys include Springfield, Illinois; Roanoke, Virginia; Duluth, Minnesota; Sioux City, Iowa; institution services in New York State; and total program services in Maryland, as requested by the Governor. Completion of current survey commitments has occasioned a backlog of requests for similar studies. Written standards on Detention Planning has been postponed because of the extensive amount of survey work in this area. Assistance to States will be continued in this regard during 1967 and 1968.

Staff participated as delegates or representatives of the Bureau at a variety of State, national and international conferences focusing on areas of special needs in the field of juvenile delinquency. These conferences included: the Inter-Regional Meeting on Research, Copenhagen, Denmark, the Third United Nation's Congress on Crime and the Treatment of Offenders, Stockholm, Sweden, both in August 1965; the Police Institute in Pennsylvania, Training Probation Officers and Juvenile Police Officer's Meeting in Chicago, Illinois, the Biennial Conference of the American Public Welfare Association, and the Specific Task Force program of the Joint Commission on Correctional Manpower and Training, as well as the Secretary's Committee on Juvenile Delinquency, the Florida State Juvenile Delinquency Committee, the National Council of Negro Women, the Conference of the New York Training Schools, and the Conference of Superintendents of Correctional Institutions, as well as meetings of the International Association of Chiefs of Police, the Metropolitan Juvenile Officers Training Workshop, Kansas City, Missouri, and the school of Police Administration at New Mexico State University. Law enforcement training and training techniques in processing delinquents have been the point of emphasis at meetings of persons in the correctional field.

The following publications and/or articles have been issued during the last fiscal year:

Standards for Juvenile and Family Courts, C.B. Pub. No. 437, 1966.

"Closing the Gap in Social Work Manpower" Field report of the Departmental Task Force on Social Work Education and Manpower, published by D.H.E.W.

Legal Bibliography for Juvenile and Family Courts, C.B. Pub., 1966.

"Intake and Orientation Procedures in Institutions for Delinquent Youth," FEDERAL PROBATION, March 1966.

"Problems and Progress in Staff Training," CRIME AND DELINQUENCY, vol. 12, No. 3, July 1966.

"Recreational Programs in Institutions for Delinquent Youth." In Readings in the Administration of Institutions for Delinquent Youth.

b. *Office of Juvenile Delinquency and Youth Development.*—

Demonstration: In the initial years of the Office of Juvenile Delinquency and Youth Development, the congressional mandate to develop a fresh approach to the perplexing problems of juvenile delinquency was implemented through the development of a series of broad-scaled, comprehensive demonstration programs. Based upon the assumption that a good deal of delinquent behavior is caused by the current arrangements of society, these projects were aimed primarily at changes in social situations affecting delinquent or potentially delinquent youth. Concentrating on the deprived intercity areas which have the highest delinquency rates, these pioneering projects mobilized community resources to attack the conditions which brought about delinquency. They emphasized prevention as well as control, and recognizing the interrelatedness of youth problems, they included intensive efforts and coordination on the part of educational, employment, health, welfare, law enforcement, correctional, neighborhood organizations and other agencies concerned with youth problems. Many of the hallmarks of these juvenile delinquency programs have become official policies and programs in such Federal efforts as the Anti-Poverty Program, the urban Development Demonstration City Program, Labor Department Youth Employment Programs and Educational Programs.

As it became clear that the Office of Economic Opportunity was developing a larger program and utilizing many concepts similar to those developed in the Juvenile Delinquency Program, the responsibility for financing these projects was transferred to the Anti-Poverty Program. By the end of fiscal year 1966 the transfer of all comprehensive projects was successfully completed, and the Office of Economic Opportunity assumed the funding of the youth delinquency programs. The only exception to this was the comprehensive delinquency program in the District of Columbia, where the Office of Juvenile Delinquency and Youth Development maintained a statutory responsibility.

Although fiscal responsibility for these programs has been transferred to the Office of Economic Opportunity, the Office of Juvenile Delinquency and Youth Development maintains contacts with these projects so the Nation may have the benefit of the new knowledge which has been produced in the field of juvenile delinquency.

With the transfer of these projects, a program of special demonstration grants begun in fiscal year 1965 was expanded and intensified in fiscal year 1966. Spread throughout the Nation, in rural areas, small towns and suburban communities, as well as the slums of our large cities, these short-term projects, capitalize upon the techniques and approaches developed in the comprehensive programs. They concentrate upon delinquents, youth who are in danger of becoming delinquent, and youth who have not been served effectively by social or educational agencies. But their major objective remains unchanged: the development of innovations which have the potential for wider adaptation and which deal with the social conditions that foster delinquency and anti-social behavior.

In fiscal year 1966, 21 Special Demonstration Grants were awarded. Of these, eight were for the continuation and conclusion of projects begun in fiscal year 1965. Among these continuation grants were:

Two projects in Newark, New Jersey and Louisville, Kentucky which offer a community based alternative to institutionalization. Employing techniques known as guided group interaction which capitalize upon the influence which young people can have upon each other, these programs offer a less expensive and potentially more effective substitute for the incarceration of young people.

The use of roving consultants to work with the parents and teachers of children with school behavior problems in Tucson, Arizona is representative of what can be done in sparsely settled areas where there is a shortage of professionals to work with delinquent youth.

A community based self-help program leading toward abstinence among users of narcotics and dangerous drugs is underway in Berkeley, California. Utilizing ex-addicts on the staff, two centers serve as an avenue from the drug world back to conventional society.

The use of rival youth gang leaders to improve inter-ethnic relations and reduce juvenile delinquency is being tried in three contiguous neighborhoods of Brooklyn which have been plagued by teenage violence.

These projects which were refunded during fiscal year 1966 will be completed during fiscal year 1967, and their final reports and evaluations are expected to produce valuable insights which can guide the efforts of other communities in the Nation.

The experiences of earlier grants helped to generate, in fiscal year 1966, a host of new ideas which were presented for funding to the Office of Juvenile Delinquency and Youth Development. Of the 13 new grants awarded in fiscal year 1966, a few are noted below:

Because of the explosive potential in the hositlity which exists between residents of intercity ghettos and the police, a grant was awarded to the North City Congress in Philadelphia for a program to improve police-community relations. The Philadelphia Police Department is cooperating fully in this program, which is operated by the residents of north Philadelphia and which creates opportunities for police and residents to confront each other, to share their concerns, to learn from each other, and to change their attitudes and practices with regard to each other. This grant is coordinated with a training grant from the Office of Juvenile Delinquency and Youth Development which was awarded simultaneously to prepare police officers and administrators as well as community residents for their new role in the community relations program.

Always seeking new alternatives to institutionalization, the Office of Juvenile Delinquency and Youth Development awarded a grant to Outward Bound, Inc. In a carefully evaluated program youth who would have otherwise been committed to institutions in the Commonwealth of Massachusetts spent a month at an Outward Bound Camp where they experienced a rigorous program designed to help them reach new levels of achievement.

In an institutional setting, the Institute for Behavioral Research, Inc. was awarded a grant to follow-up on an earlier experiment at the National Training School for Boys. This corrections program, based on principles of operant conditioning and learning theory offers rewards to boys for socially acceptable, constructive behavior. Based on indications thus far, this approach is much more successful with boys than traditional institutional practices, and as a result the program is playing an important role in generating significant changes throughout the institution. A great deal of interest has been shown in this program throughout the Nation, and the Federal Bureau of Prisons, which also supports the project is disseminating knowledge of the techniques to other institutions.

Significant innovations in court procedures have been developed in Boulder, Colorado where the court is experimenting with new uses for volunteers. In New York City, Fordham University, with the cooperation of the local courts and New York University, is developing new community oriented diagnostic tools for use by juvenile court judges. If successful, this project will enable the court to deal with the community factors contributing to delinquency as well as to the individual needs of young people brought before it.

A new approach to reducing the attractiveness and cohesion of juvenile gangs has been developed by the University of Southern California out of some years of research on the traditional gang work practices of the official agencies of Los Angeles County.

Because many young people released from correctional institutions find it difficult to enter productive career lines and avoid further delinquencies, the University of Notre Dame, the Inland Steel Company, and the Indiana Correctional System are cooperating in a program designed to prepare inmates for employment. This unique combination of resources could serve as a milestone in finding new ways for industry to help and to utilize the talent of young people who have few opportunities for achievement.

Based on the assumption that a key factor in delinquency prevention lies in giving youth a significant role in those areas of community life which have meaning for them and impact upon them, the University of California has received a grant to enable middle class youngsters in Contra Costa County to work closely with the adults of their community in developing a system of informal controls to prevent delinqency. In Columbus, Ohio, a grant to the East Central Citizens Organization established a youth-managed facility where young people determine the policies of programs in recreation, education, and social services, and also have an opportunity to seek change in the community's institutions through continuing dialogues with significant local officials. And in the East Village Section of New York, the New School for Social Research is conducting a program at St. Marks Church in the Bowery which utilizes artistic media to attract and develop the potentials of alienated, uncommitted youth.

In fiscal 1967, several areas will be selected for priority attention. They may include such things as year-round efforts to prevent conditions which lead to summer riots; the development of opportunities for predelinquent and delinquent young people to develop career lines in the social services; opportunities for alienated hostile or uncommitted members of the Nation's youth subculture to be brought into the mainstream of society as first class citizens; and new means for existing community institutions to prevent the labeling of young people as delinquents by handling certain categories of behavior outside of the courts.

Training

This phase of the program authorizes grants and contracts for the purpose of training personnel employed or preparing for employment in programs for the prevention or control of juvenile delinquency or youth offenses. Through fiscal 1966, programs supported by these grants trained over 26,900 personnel. Indirectly, by establishing Training Centers and curriculum development projects which are developing knowledge that is being fed systematically into a variety of curricula, this program will have contributed to the training of thousands of additional personnel by up-grading the quality of the knowledge transmitted to them.

The Training Centers established by the Office of Juvenile Delinquency and Youth Development have proven to be effective mechanisms for involving the relevant expertise of universities in studying the problems of delinquency and in training a variety of levels of personnel to work with problem youth. Several Federal departments have replicated the Training Centers for use in their own programs.

The Centers have had a significant impact on traditional courses in their respective universities. The Training Center at Howard University stimulated the development of an interdisciplinary graduate program in youth work. The Training Center at the University of Minnesota produced a video taped course for teacher education which is being used by the College of Education.

The Training Centers have continued to develop new techniques and methods for instruction. The Training Center at the University of Texas developed a productive technique for sensitivity training for the police, judges, and correc-

tional personnel throughout a five-State regional area. All of the Centers worked with community leadership at a variety of levels toward the development of new programs for delinquent youth. The University of Hawaii has taken leadership in the creation of a statewide task force on youth and Corrections. Boston University developed a police-community relations program in which significant elements of the community were brought together around the problems of youth. The University of Minnesota provided effective leadership in establishing training programs for volunteers in the community. Southern Illinois University was instrumental in introducing needed changes in youth correctional facilities. Howard University developed a program with the D.C. Board of Education for the training of educational aides who will work in the school system.

The provision of consultative services to community agencies, city and State officials became an integral function of each center, and the centers continued to be used as training resources by organizations such as the National Council on Crime and Delinquency, the Council of State Governments, and the Council on Social Work Education; and by the Federal agencies such as the Department of Labor, the Office of Law Enforcement Assistance, and the Office of Economic Opportunity.

The experiences of the Training Centers indicates the need not only for continuation, but an expansion of efforts. With the increased financial aid in 1967, three developments can take place:

1. The capability of universities to broaden the scope of their training will be greatly enhanced.

2. The Training Centers will be in a position to develop new curriculum materials and refine and test those which have been developed in past years.

3. As the training centers have become accepted and proven their value, requests for training programs and technical assistance on persistent problems such as probation services, handling of youth by the courts, working with youthful gangs, etc., have increased. Additional support will enable them to meet these requests and assume an every increasing leadership role in their region.

Curriculum Development grants are designed to overcome the dearth of useful materials available for training purposes, to update existing materials and to translate the knowledge based on research into practical guides for agency workers. Through curriculum grants, a variety of new materials has been produced: training manuals, syllabi, guidelines for designing programs, reference books and visual aids. In 1966, 89 documents were completed. A highlighting of the significant materials developed in 1966 follows:

Guidelines for the planning and operation of Neighborhood Service Centers.

Manuals on group counselling in correctional settings.

Materials for training clergy to work in low income areas.

Materials to assist probation officers to make more effective use of community resources.

New curricula in community organization for use in graduate schools of social work.

Materials for personnel working with low income girls.

Studies in the problem of youth violence.

Materials for use in police-community relation programs.

Guidelines for the training of indigenous workers.

Areas of emphasis in curriculum development grants in fiscal 1967 will include:

Citizenship and leadership training for both adjudicated and predelinquent youth.

Continued exploration and development of materials for the training of subprofessionals for work with delinquent youth and the establishment of career lines for these personnel.

The development of training materials in the area of nonjudicial handling of juvenile delinquents as an alternative to official adjudication by the courts.

Training materials dealing with the juvenile court process for lawyers and related social welfare personnel.

Materials on the training of youth as tutors for other youth.

Development of materials to provide for a comprehensive and integrated correction training program for personnel involved in the system from arrest through release.

The development of materials dealing with youth involvement and the youth culture.

Short-term workshops reached all levels of school personnel, welfare workers, law enforcement officers, civic leaders, judges, volunteers, clergymen and citizens with an interest in delinquency. They stressed an interdisciplinary and interagency orientation and the communication of new techniques and information. These programs were intended to assist trainees to examine the adequacy of existing services, to plan needed changes and to initiate new services. Also, these short-term training programs proved to be effective means of disseminating the knowledge gained from curriculum development projects. Examples of these training efforts were:

Police Training Workshops: designed to improve their work with juveniles, the training has focused on such areas as police-community relations, the social and legal aspects of delinquency, and the responsibility of the police to the child and to the community. As the result of the efforts of one project, several police jurisdictions of one county are combining their resources in working with the problem of juvenile delinquency.

Workshops were conducted with teachers of Indian children focusing on the problems of these children and how these problems could lead to delinquent behavior without skillful intervention by understanding adults.

A unique series of workshops and institutes have been helping the labor union leadership of one State to develop a viable role for unions in the control and prevention of juvenile delinquency.

The first national conference on amphetamine abuse was held in February 1966. The objectives of the conference were: to help participants with problems of disseminating information on the growing abuse of amphetamines, especially among young adults; to explore possible ways of setting up a long-term method of collecting data about and working toward the control of these drugs; to identify effective ways to communicate about amphetamines; and to focus national attention on the problem. A similar conference is planned in fiscal 1967.

A national conference on the problems of training personnel in community action programs produced important material pertaining to gaps that currently exist in these programs.

As in the past, the short-term training programs will continue to serve as prime vehicles for the dissemination of the results of curriculum development. 1967 will offer the opportunity to utilize the short-term workshops as a means of disseminating knowledge gained through the demonstration projects.

Program Analysis and Dissemination of Information

In fiscal year 1966, the Office of Juvenile Delinquency and Youth Development has made a major investment in analyzing and assessing the results of programs funded by the Office during the past 5 years. The overall goal has been to document the significance of programs supported by the Office with reference to the following:

1. Contributions to the present state of knowledge and practice.
2. Impact on local, State and National level.
3. Implications for policy, programs and further study.

Systematic program analysis began in September 1965. There is yet a great deal to be done, but the accomplishments of program analysis thus far have been useful to the Office in assessing new developments, trends, problems, and gaps in particular functional areas; and in guiding, implementing and revising programs and policies. The specific program analysis tasks that have been undertaken include:

1. Inventory, Referencing, and Analyzing Grant Products. Examples of these tasks include:

a. Maintaining and monitoring systematic files and lists of products.

b. Classification of products. (Over 1,000 documents resulting from Office of Juvenile Delinquency and Youth Development funded project activities have been classified according to a substantive area code which represents a categorical description of the types of materials on file.)

2. Review of Project Accomplishments and Elaborating their Objectives. This has involved formulating and operationalizing questions regarding the outcome of our grant activities and collating and preparing material which will enable the Office to answer procedural, policy, or substantive questions raised

in the course of administering the program. Specific examples of activities in this category are:

a. Formulation of analytic plans.

b. Compilation and summarization of project findings and accomplishments in accordance with our analytic plan.

c. Qualitative assessment of project findings and accomplishments in specific substantive areas.

d. Preparation of position papers which are based on data derived from the specific analytic reports.

In-depth analytic reports which have been completed and which are now being prepared for publication or which are being utilized along with other data to answer basic questions relative to the Office's total program efforts include:

1. An exploration of present experimentation in the use of non-professional personnel in correctional settings.

2. An analysis of neighborhood-based multi-service centers in five cities.

3. Problems of planning and operating youth employment programs for disadvantaged youth.

4. A critical review of training programs for disadvantaged youth.

5. A study of planning for the prevention of juvenile delinquency: a study of the comprehensive demonstration projects supported by the Office of Juvenile Delinquency and Youth Development.

6. A study of neighborhood organization components in comprehensive delinquency prevention projects.

7. An analysis if selected Office of Juvenile Delinquency and Youth Development funded projects concerned with the administration of juvenile justice.

8. An analysis of several curriculum development reports which describe police interaction with juveniles.

In addition, the Office also contracted for the preparation of 5 position papers on critical issues in delinquency prevention and control. There are position papers which draw not only from the experiences of Office of Juvenile Delinquency and Youth Development funded programs, but from the field as a whole. The papers have been useful, not only in formulating Office policy and program direction, but in the assessment of delinquency and crime made by the President's Commission on Law Enforcement and the Administration of Justice.

Materials have been made available and special reports prepared for grantees, universities, national organizations and other Federal agencies, such as the Office of Economic Opportunity, the Office of Education, the Labor Department and the Law Enforcement Assistance Agency. Detailed descriptions of more than 100 projects were prepared for the Crime Commission for use in a study of the policies and programs directions of Federal agencies concerned with juvenile delinquency. To facilitate the efforts of the Office to provide grantees with a constant flow of information from grant activities, the Information Center of the National Council on Crime and Delinquency provides copies of Office of Juvenile Delinquency and Youth Development materials upon request. The Center publishes bi-monthly newsletters to provide grantees with current information on grant activities and accomplishments.

2. PUBLIC HEALTH SERVICE

National Institute of Mental Health

Antisocial behavior—ranging from truancy, window-breaking, and petty thievery at one end of the scale to mass murder at the other—is a major problem in our society. This criminal and delinquent behavior is symptomatic of troubled individuals and a troubled society. The problem is so vast that the President has appointed a Commission on Law Enforcement and the Administration of Justice, with which the Institute is working to develop a national program of prevention and control.

Serving as the focal point for the Institute's activities in this field is the Center for Studies of Crime and Delinquency. The Institute's efforts to help the Nation control and prevent crime and delinquency include research on the causes of antisocial behavior, the training of professional and non-professional personnel to work with the socially deviant, direct intervention with street corner gangs and other delinquents, work with offenders in institutions, studies to determine the most effective means of rehabilitation, investigations of the circumstances lead-

ing to mass violence, and studies of the factors that combine to produce violence-prone and homicidal individuals.

Because the problem of juvenile delinquency can be dealt with most effectively by dealing with conditions giving rise to it, the Institute has supported numerous studies to learn as specifically as possible the causes of delinquency. Institute-supported studies in this area have focused upon such issues as the attitudes, child-rearing practices and composition of families in the rundown, high delinquency areas of large cities. For example, one study concerned with the role of the father found that homes in which the father is absent or pushed aside may foster delinquency through a psychological process leading to "defensive masculinity" or "compulsive masculine behavior." The study found that the boy identifies with his mother for a period of time, and then makes an over-compensating effort to prove his masculinity. Cross-cultural evidence supporting this theory was provided by a recent study conducted in the British Honduras. Research is also being conducted of delinquents from families at the upper socioeconomic levels.

Studies to verify and extend these research findings will continue to be supported. On the basis of already accumulated facts, for several years the Institute has been suggesting and supporting efforts which attempt to prevent or lessen the social and psychological disabilities too frequently present in youth from the poorest neighborhoods and which too frequently, through the process of cultural inheritance, are passed on by them to their children. As these efforts show promise, the Institute enlist the support of other agencies in continuing and enlarging them. For example, earlier studies of delinquent gangs indicated the value of the so-called "detached worker." The Office of Economic Opportunity is currently supporting the Chicago STREETS Project, under which detached workers operating out of four Chicago agencies will work with both street corner youth and their families. The project will seek to prove more conclusively than in the past the effectiveness of the detached-worker approach in preventing delinquent activity and helping delinquents achieve a satisfying and lawful life. And, as part of the Institute's collaboration with OEO, the Crime and Delinquency Center developed and participated in a research utilization conference related to the Chicago project held during the current fiscal year. The conference was part of a continuing effort to assist other agencies in the evaluation of projects supported by them.

NIMH supports a number of efforts to demonstrate means of improving the institutional treatment of delinquents. One such Institute-supported program demonstrated that even inmates who perceive themselves as "sure losers" can be motivated to take part in a self-instructional program. As an example of what can be done, the program enabled twelve young men who had not gone beyond the eighth grade to complete high school and be accepted into college, all while in prison. The project sought to meet the offenders' needs both for formal education and for vocational training and thus to prepare them for life outside. Both self-instructional courses of many types and group-discussion sessions, designed to arouse interest and strengthen motivation, are provided. Based on this experimental work, major projects have been undertaken at this institution with the support of the Department of Labor and the Vocational Rehabilitation Administration. More than 90 percent of the inmates are now engaged in some sort of educational activity. The program could well become a model for use elsewhere. Other efforts aimed at improving institutional treatment have included the establishment of community living units within the institution and the use of group and milieu therapy techniques.

Another area in which the Institute is very much interested is treatment of the delinquent within the community. Efforts to date suggest that such treatment is successful. Perhaps the most noteworthy example is the Community Treatment Project in California, which has been comparing two groups of delinquents. The *controls* received the regular institutional treatment and were then paroled; the *experimentals* were released directly to their home communities, where their recreational activities were closely supervised, and they received psychotherapy and aid in finding jobs. The findings to date are highly encouraging. The delinquents treated in the community have made a significantly better parole record than the others and they tend to show, on a psychological test, more improvement in their personal and social adjustment. The director of California's Youth and Adult Correction Authority says the project has "saved the State of California $20,000,000 in construction costs." Besides demonstrating the effectiveness of treatment in the community, the in-

vestigators have divided delinquents into a number of types and specified the kind of treatment likely to be most effective for each type. The work in progress includes tests of these findings.

Other areas of Institute concern include: the provision of information that will enable communities to improve the probation process, the development and utilization of systems for distinguishing among types of delinquents on the basis of personality characteristics rather than on the type of offense committed, and the utilization of the offender himself in programs to prevent crime and delinquency and to rehabilitate the criminal and the delinquent. Twenty former offenders have successfully been placed in a variety of new human-service careers, and a national conference was held by NIMH in September 1966, to describe the problems associated with such use of former offenders and to develop possible solutions. The proceedings of the conference will be published. In addition, the Institute supports a number of projects to provide training in mental health to professional persons concerned with the problems of crime and delinquency.

Because information on crime and delinquency throughout the world, including the results of research projects and control measures, has been growing rapidly, the Institute has, for some time, supported efforts to make this information available to interested agencies and individuals in the most useful fashion. The "International Bibliography on Crime and Delinquency," prepared under contract by the Information Center on Crime and Delinquency of the National Council on Crime and Delinquency, contains not only abstracts of the current professional literature but also hitherto unpublished reports of on-going research, demonstration projects and action programs.

The Institute has moved to meet the problem of mass violence through the establishment of a consortium within NIMH designed to provide an informed resource on and to develop programs for the prevention of the problem. A special grant has been awarded to the Center for the Study of Violence at Brandeis University to collect information about three communities of varying sizes in the North, and an equal group matched for size in the South, selected on the basis of their possessing a high possibility of violence. Should an incident occur, the events leading to and flowing from it will be studied in detail. Among other expected results, the project will identify signals of impending violence and recommend procedures for prevention and control.

Additional areas of NIMH concern are the development of a better understanding of the factors—personal, family, social—related to aggressive and violent patterns of behavior, and the development and testing out of a classification framework for violent acts and for violent-prone individuals to the end of effecting both preventive measures and treatment programs fitted to the needs of the individual.

Additionally, under the Institute's Hospital Improvement program, the therapeutic and rehabilitative efforts of five maximum security hospitals serving mentally disordered offenders have been strengthened, and awards for improving in-service training facilities for the staff of maximum security hospitals are being made by NIMH.

3. OFFICE OF EDUCATION

Juvenile Delinquency

The 1966–67 school year marked the beginning of a new grant program administered by the U.S. Office of Education on behalf of children in institutions for juvenile delinquents. This was authorized by the 1966 amendments to Title I of the Elementary and Secondary Education Act of 1965 (P.L. 89–750).

Grants are available to State agencies for those institutions which operate a school program and to local educational agencies for other public and private non-profit institutions for delinquents. Grants are based on applications which must describe the special education needs of the youth in the institution and propose a project designed to meet the most crucial of these needs. While the U.S. Office of Education administers the provisions of the Act and provides program leadership, it is the State departments of education that are authorized by Title I to approve project applications.

The entry of the official education agency of the Federal Government into the administration of a grant program in the field of juvenile delinquency implies a recognition on a national scale of the importance of education in the amelioration of one of the nation's most urgent and pervasive problems. Delinquency represents serious failures of families, schools, communities and society at

large, as well as of the institutionalized children who find themselves unable to "make it" in the free world and are on the threshold of crime. The condition of overcrowded juvenile facilities and the acute shortage of qualified service staff presents an appalling picture of enlarging concentrations of delinquents whose needs are not being met. Consequently, further hardening of attitudes and increasing inadequacies develop among many of the juveniles who are but a short step from entering the criminal sub-culture found in prisons.

Most agencies operating institutions for juvenile delinquents have had neither the resources nor the technological know-how to provide the kind of learning experiences that have a real impact on the lives of the young people in their care. To be fully effective, educators cannot remain insulated from the realities which cause and perpetuate the problem of delinquency. Education in isolation cannot possibly meet the needs of institutionalized delinquent children whose attitudes and values must be reached and whose predicament must be understood and treated within the context of their total environment, whether in institutions or on the street.

The role of education, then, is to address itself to the problem of juvenile delinquency with full awareness of its complexity which extends beyond the individual child during the limited time he is compelled to sit in a classroom. The teaching of academics must relate meaningfully to the delinquents' other treatment, work and living experiences. Well planned and coordinated involvement of teaching staff with parents, psychologists, psychiatrists, and social workers, administrators, work supervisors, resource specialists, community, and other related agencies must be achieved nationwide before success of broad scope can be expected. Assessment criteria must be developed in terms of the objective of rehabilitating delinquents as self-respecting, law abiding, useful citizens through the process of developing socially acceptable self-motivation.

The new amendment to Title I of the Elementary and Secondary Education Act opens up the possibility of working toward these educational goals for juvenile delinquents on a national scale. The grant funds authorized by the amendment amount to about one-half the State per pupil expenditure for public education for each child living in the institution. The fiscal year 1967 appropriation for State agencies was about 20 percent of the full authorization and for local agencies about 85 percent. This level of funding will make possible a beginning in planning, organization and much-needed inservice training for teachers.

Funds can be utilized for administrative "tooling up" as well as to support the initial projects which, hopefully, will produce noteworthy models and give direction for nationwide efforts in fiscal year 1967. Formulation of sound planning, organization, coordination, dissemination of information, and the training of critically needed staff must take place to develop a framework within which quality performance can be possible. The fiscal year 1968 appropriation will provide the basis for significant advances in the understanding of the problem, improvement of teacher training, establishment of channels for closer coordination among staff members and agencies serving a common purpose and development of curricula especially suited for the needs of delinquent children.

Title III of the Elementary and Secondary Education Act (P.L. 89-10) provides nonmatching grants directly to local education agencies to stimulate and assist in (a) the provision of vitally needed educational services not available in sufficient quantity or quality, and (b) the development and establishment of exemplary educational programs to serve as models for regular school programs. This program gives special consideration to projects that are truly innovative as well as being of high quality and responsive to local needs.

Title IV, Part A of the Library Services and Construction Act Amendments of 1966 (P.L. 89-511) provides for books, other library materials, and library services to be made available to inmates of State reformatories and penal institutions under approved State plans for establishing and improving State institutional library services. Funds have been appropriated in fiscal year 1967 for planning purposes only. In addition, funds allotted to States under Title I of the Act for public library services can help to alleviate juvenile delinquency. The public library and several community agencies in Richmond, Indiana, have worked together to determine the special needs of this group for materials and services and to supply these services. Special training for the staff and in-service training for students is included in this project. Similar programs are being conducted in Brooklyn, New York; Los Angeles and Oakland, California; and Cairo, Georgia.

In fiscal year 1966 there were 27 programs begun in 21 States under the provisions of Title I of the Higher Education Act (P.L. 89-329) which focused on the problems of youth. These programs include the counseling and training of youths in correctional institutions to rehabilitate them and help them re-enter society; training teachers and school guidance personnel to work with youths to help prevent drop-outs which can lead to delinquency; strengthening the role of probation officers, retraining law enforcement personnel ,and clarifying juvenile court procedures to cope with the problem of juvenile crime; identifying, counseling and training culturally disadvantaged out-of-school youths to help them discover their abilities and find useful employment; and helping parents and society to better understand youths and their behavior patterns.

Vocational educational training programs have been initiated in correctional institutions in several States including Arizona, Arkansas, and Montana. Since the school drop-out is a potential delinquent, occupational orientation projects designed to prevent drop-outs and to encourage drop-outs to return to school are being conducted in several States including California, Massachusetts, North Carolina, Ohio and Texas. This type program is designed to raise the intellectual performance of the students, provide intensive counseling, give them opportunity to experiment in a variety of course offerings, and introduce them to the world of work.

Since the inception of the Manpower Development and Training Act, opportunities for occupational training have been given to youths under 21 years of age and a portion of these youths referred for training have had records of a minor or major nature. Special institutional training programs have been set up especially for youths and many other youth have been trained in regular institutional programs in which youths and adults have shared the instruction. In addition, the Act provides special programs of testing, counseling and referral of youths. Further efforts directed to the prevention of juvenile delinquency through meaningful work have been through placement of youths in MDTA programs when Neighborhood Youth Corps programs have been completed. The 1966 Amendments to the Act provide for the development and carrying out of experimental and demonstration programs for training and education for persons in correctional institutions who need such training to obtain employment upon release and fill a useful place in society.

During fiscal year 1966 the Expansion and Improvement of Vocational Education program supported two projetcs to explore the degree which vocational education and guidance during incarceration, combined with supportive and placement services following release, may serve to restore youthful offenders to the community as functioning useful citizens.

Forty high school dropouts in the Washington, D.C. metropolitan area participated in a program directed by the Washington School of Psychiatry to attempt to restructure social attitudes and provide vocational training concurrently. The participants are hard core juvenile delinquent recidivists who have extensive police records and, therefore, are not eligible for Job Corps or similar occupational training programs or return to the D.C. Public School System. Part time work was performed in community-related activities and each enrollee was responsible for his part in maintaining the training center in northwest Washington, D.C. Several of the group are now employed full time and are making a positive contribution to their community. Six members of the group successfully completed the High School Equivalence; of this group three are being prepared for college entrance in fiscal year 1967. A U.S. Office of Education grant provided funds to develop a basic educational program utilizing existing and experimental program instructional materials, field trips, lectures, and a tutorial program in an effort to raise the basic skills of this population. At the same time, social behavior was tested through the use of a reward system. These rewards were based on the social and academic performance of the students.

Late in fiscal year 1966, the Office of Education, in cooperation with the Department of Labor and the Office of Economic Opportunity, funded a $4.3 million demonstration training center in the Bedford-Stuyvesant area of New York City. Project TRY, the acronym for Training Resources for Youth, Inc., was established to provide a comprehensive educational environment for "culture of poverty" youth to develop educational, vocational, and social skills required by today's modern community. Six occupational training offerings are the major part of the vocational program and include: automotive-diesel service and repair,

food service, vending machine service and repair, business and clerical machine service and repair, heating-refrigeration servicing, and appliance service and repair. Placement, including post-training counseling, is the final phase of this multi-agency cooperative project. Initial evaluations by representatives of the three Federal agencies discovered some organizational problems that were subsequently resolved; the project now appears to be making a positive contribution to this community which has been the scene of racial unrest and rioting in the recent past.

The Research and Training program also supported four research projects in such areas as prediction and prevention of delinquency and an English curriculum for training schools.

4. VOCATIONAL REHABILITATION ADMINISTRATION

Juvenile Delinquency

In its efforts to provide vocational rehabilitation services to the juvenile delinquent, the Vocational Rehabilitation Administration is effectively demonstrating the flexibility and versatility of the public rehabilitation program. As a rehabilitation agency its primary orientation is correctional. Its preventive potentials, however, are finding expression in diverse programs being developed throughout the country.

For a client to be eligible to receive vocational rehabilitation services a physical or mental disability must exist. Included within the definition of physical and mental disability are those behavioral disorders characterized by deviant social behavior or impaired ability to carry out relationships with family and community. Studies have shown that within delinquent populations a relatively small number have physical disabilities. A much greater number have mental disabilities, generally in the form of mild mental retardation. There is a very sizeable group, however, whose disability is essentially behavioral and the 1965 Vocational Rehabilitation Act Amendments have provided the opportunity for broadly extending vocational rehabilitation services to this group of disabled young people.

Correctional rehabilitation services

State vocational rehabilitation agencies have been steadily organizing programs and services for the juvenile delinquent and other public offenders.

Under the Basic Support program, and related grant programs, for example, a number of State agencies are providing comprehensive rehabilitation services to adjudicated youthful offenders. An effective device has been the establishment of institutional rehabilitation units, which offer a full range of vocational rehabilitation services and show great promise of contributing to a reduction in the recidivist rate. The Georgia Division of Vocational Rehabilitation has developed a unit of this type at the Georgia Industrial Institute. This program offers vocational rehabilitation services concurrent with and subsequent to incarceration and encompasses such functions as screening, vocational appraisal, prevocational evaluation, physical restoration, prevocational training, specific vocational training, counseling and guidance, job placement and follow-up. Similar institutional programs for young offenders are found or are being developed in Arkansas, California, Kansas, Connecticut, Iowa, Maine, Maryland, New Jersey, New York, North Carolina, Ohio, Oklahoma, South Carolina, Tennessee, Texas, Vermont, Virginia, West Virginia, and Wyoming.

A related correctional service program has been established under the VRA research and demonstration program in eight Federal prisons spread across the country from Tampa to Seattle. These eight separate projects have been designed to demonstrate and test different ways of developing vocational rehabilitation services to Federal offenders, and may well set the pattern for future programs for State and local offenders.

Many institutions for juvenile offenders are served by a vocational rehabilitation counselor from the local office of the State vocational rehabilitation agency. In Arizona, for example, both the Arizona State Industrial School for boys and the Good Shepherd School for girls are visited regularly in order to provide basic evaluation, counseling and vocational planning. The Buena Vista, Colorado State Reformatory is served by the vocational rehabilitation counselor one full

day a week. Other institutions are visited at comparable intervals and in California alone nineteen counselor positions have been established to serve offenders from district offices.

Throughout the country State vocational rehabilitation agencies are planning and preparing for the full-time assignment of counselors to correctional institutions. Full-time counselor assignment has been developed in Wisconsin and is underway in Nebraska and New York.

In Oregon the State vocational rehabilitation agency is exploring the establishment of a halfway house for delinquent youth as an alternative to incarceration. In the District of Columbia, Rhode Island, Alabama and other States programs have been developed in conjunction with family and juvenile courts. These programs involve an evaluation of the delinquent with a view towards providing necessary restorative services. State vocational rehabilitation agencies in Arizona, Florida, and Texas have been maintaining close liaison with State probation agency personnel to develop programs for parolees and probationers. In virtually every State correctional and vocational rehabilitation personnel are exploring ways of providing improved and expanded services to the juvenile delinquent.

Preventive Rehabilitation

Research has shown that within the youthful offender population, there is a sizeable proportion of young people who would qualify for special education classes.* Programs of this type have spread rapidly throughout the country and the Vocational Rehabilitation Administration and the Office of Education are jointly encouraging the establishment of new programs and the improvement of existing ones.

It is hoped that a further articulation of this effort will present the predelinquent who has limited mental ability with an alternative to school dropout and delinquent behavior patterns.

Research

VRA research and demonstration authority has supported the establishment of correctional rehabilitation units at selected institutions throughout the country. Other research has been supported to develop: (1) a treatment center within a residential school in New York for emotionally disturbed adjudged to be juvenile delinquents; (2) a prevocational curriculum in Illinois for slow learners considered delinquency prone; (3) a study in Oklahoma of the rehabilitation needs of the juvenile delinquent; (4) a comprehensive program within a rehabilitation facility in Minnesota for parolees from a State reformatory; (5) a study in South Carolina of the effectiveness of intensive rehabilitation services for public offenders; (6) a rehabilitation program for municipal public offenders in Louisiana; (7) a study in Washington of the influence of identification opportunities on the behavior of adolescent delinquent boys and (8) a study in the District of Columbia to determine essential features of a rehabilitation program for young handicapped inmates of a correctional facility.

Training

Under its training group VRA has been supporting conferences bringing together professionals from both the correctional and rehabilitation fields to explore ways of working more closely together. Recent conferences have been the Midwest Institute of Correctional Manpower and Training, Topeka, Kansas; Institute for Meeting Manpower Needs for Correctional Rehabilitation in the South, Atlanta, Georgia; Rehabilitation of Clients with Behavioral Disorders, Norman, Oklahoma; and Effective Approaches to the Rehabilitation of the Disabled Public Offenders, Andover, Massachusetts.

Social workers trained for correctional work are also supported by the VRA training grant authority. Social work programs with correctional emphasis have been established at Bryn Mawr College, University of Washington, University of Illinois, University of Louisville and University of Missouri.

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*In virtually every State, special education-vocational rehabilitation cooperative programs have been developed to provide curricular and vocational training experiences appropriate for young people in special classes.

Correctional Rehabilitation Study Act of 1965

The shortage of skilled personnel in the field of correctional rehabilitation is a critical one. Public Law 89–178 amended the Vocational Rehabilitation Act to make special project grants available for conducting a program of research and study of the personnel practices and needs in the field, and of the educational and training resources for persons already working or preparing to enter these professions. This priority problem has been clearly identified by this legislation which has simultaneously provided a resource for planning to fill the gaps so evident today. A grant has been made to the Joint Commission of Correctional Manpower and Training which is currently undertaking its study.

Rehabilitation Research and Training Centers

The University of Wisconsin's Rehabilitation Research and Training Center is focusing its attention on a 200 block area on the poorest section of Milwaukee, Wisconsin. This project is expected to bring into play a wide range of rehabilitative measures designed to improve both the mental functioning and the general well-being of the families in this neighborhood. Although not primarily concerned with juvenile delinquency the findings should have great implication for understanding the relationship between mental retardation and delinquency behavior patterns.

Obligations for programs on juvenile delinquency

Agency	1964	1965	1966	1967 estimate	1968 estimate
Welfare Administration:					
Children's Bureau	$296,647	$327,251	$968,000	[1] 1,161,000	$1,001,000
Office of Juvenile Delinquency and Youth Development	6,851,761	11,474,984	5,892,000	7,360,000	[2]
Total, Welfare Administration	7,148,408	11,802,235	6,860,000	8,521,000	1,001,000
Public Health Service: National Institute of Mental Health	9,277,000	9,474,000	10,709,000	8,957,000	9,800,000
Office of Education	45,848	370,279	1,808,557	8,745,752	14,875,599
Vocational Rehabilitation Administration	115,339	159,207	817,000	1,162,000	1,315,000
Total	16,586,595	21,805,721	20,194,557	27,385,752	26,991,599

[1] Includes comparative transfer from Office of Juvenile Delinquency and Youth Development.
[2] Legislation for this program expires June 30, 1967. New legislation for combating juvenile delinquency is being proposed to Congress.

Blindness

Of all the disorders which afflict man, probably none causes greater problems than blindness. A recent survey shows that, next to cancer, people in the United States fear blindness more than any other handicap.

It is estimated that there are in the United States today 411,000 legally blind and 3,500,000 who have only partial vision. About half of the totally blind are not employed, and approximately 75 percent are 40 years of age and over. The National Health Survey estimates that one million people in the United States have visual impairment so severe that they cannot read a newspaper.

Federal payments to the blind amount to more than $95 million annually. Based on limited figures from New York State and Massachusetts, it is estimated that payments for aid to the blind within the States total from $600 million to $900 million annually. It is thus quite probable that the annual bill for aid to the blind approaches $1 billion, a figure frequently used though not authenticated.

Major causes of blindness and visual impairment include cataract, glaucoma, diabetic retinopathy, corneal scarring, uveitis, retinal detachment, tumors, amblyopia, and refractive anomalies.

Obligations for programs in blindness

[In thousands of dollars]

	1964	1965	1966	1967 estimate	1968 estimate
Office of Education:					
Educational improvement for the handicapped	710	968	1,282	1,680	1,680
Title III—Elementary and secondary education			28	54	100
Research and training	50	49	38	50	71
NDEA title VII—Educational media research		16			
Educational improvement for the handicapped—Research	53	103	136	135	240
Subtotal, Office of Education	813	1,136	1,484	1,919	2,091
Vocational Rehabilitation Administration:					
Grants to States	7,600	9,300	13,600	25,400	30,800
Research and demonstrations	928	1,317	1,481	1,479	1,591
Research and training (special foreign currency program)	451	532	174	281	521
Innovation grants	125	215	180	150	150
Expansion grants			122	450	550
Subtotal, Vocational Rehabilitation Administration	9,104	11,364	15,557	27,760	33,612
Public Health Service:					
Chronic diseases	606	357	378	610	80
National Institute of Neurological Diseases and Blindness	12,821	14,342	16,449	18,208	20,728
Subtotal, Public Health Service	13,427	14,699	16,827	18,818	20,808
Social Security Administration:					
Estimated benefit payment from trust funds:					
To blind persons	21,800	23,900	29,000	29,700	31,000
To families of blind persons	3,700	4,000	5,300	5,400	5,600
Adjudication of claims of beneficiaries and to maintain beneficiary rolls	2,000	2,100	2,500	2,900	3,000
Subtotal, Social Security Administration	27,500	30,000	36,800	38,000	39,600
Welfare Administration: Bureau of Family Services	51,361	51,705	57,142	66,700	69,100
American Printing House for the Blind	775	865	1,000	1,028	1,225
Total	102,980	109,769	128,810	154,225	166,436

OFFICE OF EDUCATION

Grants for the Training of Professional Personnel in Education of Visually Handicapped Children

The number of school age visually handicapped children has increased considerably in recent years. Between 1959 and 1965 there was a 38-percent increase in the number of these children registered by State and local schools with the American Printing House for the Blind. It is estimated that there are about 40,000 visually handicapped children of school age in the United States and this number is expected to rise at about the same rate as that of the general school population. Partly because of a shortage of qualified teachers many of these children are not receiving the special instruction necessitated by their handicap. More than 300 newly trained teachers are needed each year just to keep pace with the annual attrition in this area of the handicapped.

During the first 2 years of the program of professional preparation authorized by Public Law 88–164, awards have been made for 173 graduate fellowships, 47 year traineeships, 233 summer traineeships, 184 institute traineeships and 8 program development grants in the area of the visually handicapped. A total of 487 persons will receive training during school year 1966–67. It is expected that over 500 persons engaged or preparing to engage in the education of visually handicapped children will receive awards under this program during fiscal year 1967.

Title III, Elementary and Secondary Education, provides nonmatching grants directly to local eduaction agencies to stimulate and assist in (a) the proivsion of vitally needed educational services not available in sufficient quantity or quality, and (b) the development and establishment of exemplary educational programs to serve as models for regular school programs. This program gives special consideration to projects that are truly innovative as well as being of high quality and responsive to local needs. In fiscal year 1966, one project was funded for $27,553.

Title IV, Part A, of the Library Services and Construction Act Amendments of 1966 (P.L. 89–511) provides for books, other library materials, and library services to be made available to students in residential schools for the visually handicapped which are operated or substantially supported by the State. Title IV, Part B, of the Act provides for library services through public or other nonprofit libraries, agencies, or organizations, to physically handicapped persons, including the blind and visually handicapped. Funds will be allotted to States for these purposes under an approved State plan. Funds in 1967 have been appropriated for planning only.

Local libraries are currently providing services for these persons but implementation of the new legislation will permit an expanded service. To this end, some States and larger public libraries have employed staff specialists and community coordinators to work with blind and other physically handicapped persons. In addition, the New York Public Library, under a Library Services and Construction Act grant, is carrying on an experimental project to evaluate the need for, interest in, and use of large-print books for persons with severely limited vision.

The leading obstacle in expanding educational opportunities for handicapped children is the lack of qualified personnel. Second is a dearth of scientifically tested knowledge to educate these children.

In 1966, under section 302 of Public Law 88–164, approximately $136,147 was used to support five research and demonstration projects. Examples of this research follow:

A project at the American Printing House for the Blind in Louisville, Kentucky, pertains to the improvement of tactual symbols for blind children in order to contribute to their education. An attempt will be made to discover more easily interpreted symbols to be used on relief (tactual) maps. Another objective will be to increase the amounts and types of information that can be conveyed to blind children through revised maps. The distance between symbols, their height, and other factors will be studied in various combinations in order to determine which produce the greatest legibility.

The University of Louisville has undertaken a project to develop an expanded reading code for the blind. The first objective is to develop a punctigraphic stimulus alphabet that contains many more characters than the present Braille code. Secondly, when a tested stimulus alphabet is available, several response alphabets will be constructed and matched to the stimulus alphabet. The third objective will be to train people in the use of these codes and to evaluate their performance. The proposed investigation will not be undertaken with a view to replacing the present Braille code. Rather, its purpose is to determine the advantages and disadvantages of an expanded punctigraphic code.

The Office of Education supported three research projects under the Research and Training Program in the area of the blind during 1966, amounting to $38,415. The first is concerned with the comprehension of rapid speech by the blind, the second concerns school achievement and effect of type size on reading in visually handicapped children, and the third is the development of an expanded reading code for the blind.

VOCATIONAL REHABILITATION ADMINISTRATION

Scope of Problem

There are an estimated 420,000 blind persons in the United States today with an annual increment of newly blinded persons of approximately 10 percent of the total population, or 42,000. Demographers and medically oriented scientific personnel state that small annual increases are expected due to the growth of the total population and to the fact that blindness is, for the most part, the result of the difficulties which usually attend the aging process. More than 50 per-

cent of all the blind population is above age 60. A substantial number of the remaining group suffer from multihandicapping conditions. Recent advances in surgery and medicine have substantially reduced the mortality rate than was expected in the early part of the century, but those who survive suffer multiple disabilities which must be overcome if they are to lead normal lives and make their contribution to society.

Experience has shown that with good rehabilitation techniques, through training and the current job opportunities which are available to blind persons, it is entirely possible to rehabilitate at least 25 percent of the annual increment of 42,000 persons (approximately 10,500). If the backlog waiting to be served is to be considered as well as taking into account the increase in the total population, more than 12,000 blind persons each year should be rehabilitated.

At present, there are 37 separate State agencies for the blind. In the remaining 17 States and territories, vocational rehabilitation services for blind persons are provided by a specially designated unit within the organizational structure of the State general agencies for vocational rehabilitation. Under these circumstances, the disability of blindness presents a unique opportunity to demonstrate how the total job of rehabilitation can be accomplished and all services can be provided to all blind persons who can profit from them.

The Extent of Disabling Condition

Although blindness is not the total disaster that the vast majority of the general public believe it to be, it is nevertheless a severe obstacle which can only be overcome through the application of much professional skill and great courage on the part of the individual receiving the service. Contrary to the opinion of many, rehabilitation is not merely finding a job that a blind person can do, but finding the right job that suits the particular individual's aptitudes, interests, and inclinations and training him to do that job to the best of his ability so that he is thoroughly competent and is an employee that is sought after not because of his disability, but because he is a high producer who can turn his skill into valuable cash for his potential employer.

Much has been learned about rehabilitation of blind persons in the last few decades. It is now recognized that in order to attain complete rehabilitation a blind person must not only be given the skills and the tools to do an adequate job, but also the job must be commensurate with his abilities. He must be taught the skills which will make him socially as well as vocationally competent and acceptable to his sighted peers. In essence then, true rehabilitation means finding as many substitutes for sight as possible and training the blind person to utilize the substitutes to his maximum advantage. It also means the pyschological evalution of the total human being and the refocusing of the individual's talents in the achievement of a new and full life. The utimate goal of 12,000 rehabilitants is well within the realm of attainment. If adequate resources are available, this objective can be realized within the next 5 to 10 years.

Progress to Date

At first glance it might not seem that progress has been phenomenal in the last 25 years; however, after the passage of the Barden-Lafollette Act in 1943, the law which gave impetus to rehabilitation of the severely disabled, including the blind, it is significant to note that in the first year only a few hundred were rehabilitated as compared to over 6,000 during the past fiscal year. What is of even greater significance by far, however, is the variety of vocational opportunities now open to blind persons as compared with the circumscribed opportunities less than a decade ago.

Research and Training

The expansion of job opportunities is due in large measure to the amount of research, demonstration, and training which was permitted under the amendments of Public Law 565, passed in 1954. Since that time the Vocational Rehabilitation Administration has spent more than $8 million in research and training efforts demonstrating the feasibility of blind workers in such fields as computer programming, teaching in the public schools, work opportunities in numerous professions as well as many new categories of jobs in the service, semiskilled, and skilled occupations. Through long-term training grants, the Vocational Rehabilitation Administration has commenced the development of highly trained professional personnel in the field of work for the blind, e.g.,

mobility instructors, a discipline which is most vital to the rehabilitation of blind persons. It has been estimated that 90 percent of all blind citizens of the United States are unable to travel without the aid of a human guide. It is toward overcoming this grave deficiency that efforts in mobility instruction are now concentrated. It is recognized that this problem must be overcome if true rehabilitation services are to be provided to all those who desire them. Currently there are 24 rehabilitation facilities for the blind throughout the country. In order to do an adequate job, the number of facilities must be doubled and the potential of some of those already in operation increased. Research money is also being expended in the development of many electronic devices which, hopefully, will aid a blind person to travel much more efficiently than is now possible by the use of a cane. Electronic know-now is also being applied in the development of new techniques for producing Braille and for other more efficient methods of reading.

New advances in the field of optics have been developed. As a result, optical aid clinics for those with very limited sight have been opened in strategic locations throughout the country. These clinics are designed to fit blind persons, who have some slight residual vision, with microscopic and telescopic lenses which will enable them to expand their vocational opportunities, and in certain instances to make it possible for them to read the regular printed page. A great deal of perseverance in training is necessary in order for them to obtain maximum benefit of such lenses. However, the clinics do represent a great stride forward. There are approximately 26 clinics across the country, and it is hoped to open at least as many more when funds are available.

The following four illustrative examples of the many new occupational fields which have been opened for the blind within the last decade indicate positive progress:

1. Data processing, and in particular computer programing, is a whole new field which has developed within the past 10 to 15 years. Many professional rehabilitation workers for the blind felt that automation would pose some very serious problems for blind workers and would, in fact, reduce job opportunities drastically. If computer programing can be taken as one example of what will happen as our economy becomes more and more automated, there is reason for great optimism. Through some diligent research programs which have been conducted during the past few years, findings indicate that blind persons with the proper background and interest have an aptitude for computer programing and can be trained for very high level positions in this new field of work. About 150 blind persons are successful computer programers employed in industry and government, and the potential within the next 10 years, according to experts, is roughly 20 times the number now employed.

2. Service occupations, too, will provide their fair share of opportunity for well trained blind persons. It is estimated that in the next 10 years there will be created 6½ million entirely new jobs in the service field. A substantial number of these will be in the many thousands of hospitals, hotels, and motels throughout the Nation. Research and training have demonstrated that many of the jobs ranging from kitchen helper and laundry worker to telephone operator, clerk, and medical transcriber are feasible for blind persons and that well-trained visually impaired workers make desirable employees.

3. In the first decade after World War II, the majority of competitive employment opportunities for the blind were found in industry, particularly in repetitive machine operations. These opportunities were slowly eroded by the installation of highly automated machinery in the drill press operation which today has become an extremely complex job directed and controlled by a taped program. A blind person can no longer be trained as a drill press operator within a few days or even a few weeks of vocational instruction. It is now essential to provide special trade technical training for the blind worker to prepare him to compete with his sighted colleagues and obtain his share of employment in the industrial labor market. The Vocational Rehabilitation Administration is developing a long-range plan to support special units within trade technical schools designed to train blind persons to meet the numerous new challenges in this very important area of skilled employment.

4. A fourth area deriving a great deal of benefit through automation is the Randolph-Sheppard vending stand program. Progress in the number of em-

ployed operators, stand locations, earnings to operators and gross volume of business is outlined in the following table:

Randolph-Sheppard vending stand program

Fiscal year	Number of stands	Number of operators	Gross sales	Annual average earnings
1966	2,661	2,915	$65,300,000	$4,932
1967	2,850	3,140	72,000,000	5,150
1968	3,000	3,400	80,000,000	5,400

This shows a steady progress and a gross volume of business of $65.3 million in fiscal 1966. According to a recent study, the potential in this field has barely been tapped. It is the opinion of the management firm conducting the study that with the proper accommodation to automated equipment the number of stand operators now employed can be trebled and the gross volume of business within the next 5 to 10 years can be doubled. However, this goal cannot be achieved unless vending stand installations are continually upgraded, and blind operators and supervisors are kept abreast of new automated techniques. Equally important, of course, is the complete cooperation and acceptance by public and private building management.

In the last analysis, however, the measure of our vocational rehabilitation program for the blind, and, indeed, the successful effort of our entire society, will be measured not in terms of what we are able to do for those who were deprived of sight but endowed with innate ability, but of what is attained by those for whom equality seemed impossible. Vocational success and the pursuit of happiness for the multihandicapped individual, who in other societies and in former times were passed over without a second thought, must be assured an integral part of our Great Society. There are at least 2,000 of these individuals each year who can be prepared for employment in a sheltered workshop, and hopefully will progress in time to a point where they will be competitively placed in outside industry. During the past year 600 were so placed. This is a strong indication of what can be accomplished if facilities are available. With adequate resources, the initiative, ingenuity, and imagination of the State-Federal vocational rehabilitation partnership will enable blind citizens to assume full and productive lives so fundamental to the democratic principle which embodies the respect for the dignity of man.

PUBLIC HEALTH SERVICE

National Center for Chronic Disease Control

The mission of the Neurological and Disease Sensory Branch is to work with official and voluntary health agencies, professional organizations, institutions of higher learning, and other nonprofit groups to prevent, control, and eradicate, where possible, neurological and sensory impairments.

Visual disorders are of major concern to the Branch. In our modern, fast-moving society, the ability to see is understandably important. Visual ability is important to the individual person if he is to develop himself as much as he is able and make his fullest contribution to his family and to society. In addition, the blind can be a serious psychological as well as financial burden to society.

At the present time, there are about 400,000 people in the United States who are blind, and the number is increasing. The advances of modern medicine are largely accountable for this. New techniques and medicines are allowing more and more infants and children to survive complicated pregnancies, deliveries, and once fatal childhood diseases. Often, however, the child suffers some visual impairment. At the other end of the age spectrum, our older population is increasing. As people survive for longer periods, visual impairments such as cataracts and glaucoma become more apparent.

In its endeavors to help those with visual impairments, the Branch is faced with an extreme shortage of people qualified to provide diagnosis and treatment in the field of vision. There are only about 8,000 opthalmologists and 22,000

optometrists in the United States. The Branch is concerned with training these professional people needed to meet the needs of the Nation. Also, the number of orthoptic technicians and trained ophthalmic assistants is not adequate to serve the needs of the visually impaired. Recently, in an attempt to more efficiently utilize the professional talents that are available, much emphasis has been placed on training technical assistants. For instance, amblyopia ex anopsia, a leading cause of monocular blindness in children, and glaucoma, a leading cause of loss of sight in middle-aged and older people, are preventable with early detection and treatment. Because of the short supply of individuals to do complete medical eye examinations, however, screening programs are necessary to determine those likely to be afflicted and see that they get the proper medical treatment.

Short-term training is also encouraged for generalists, pediatricians, and internists to increase their competence in the general principles of visual problems and introduce them to recent developments and advances in treating patients with visual impairments. Glaucoma, amblyopia ex anopsia, ocular manifestations of systematic disease, and emergency eye care are stressed. Courses for ophthalmologists in dyslexia and the use of aids by the partially sighted are encouraged. The Program is also interested in providing short-term specialized training for nurses whose patients have visual impairments. Also of major concern is applied and clinical research to develop new diagnostic and therapeutic techniques to aid in the early diagnosis and more effective treatment of visual disorders. Interdisciplinary and long-term investigations of unexplored areas of visual impairments are urgently needed and actively promoted. The Branch is continually encouraging those clinical research and demonstration programs which allow the new discoveries from the basic research laboratory to be brought to the patient and to the community in the form of effective new techniques.

Training

During 1967, the Neurological and Sensory Disease Service Branch will support two programs in vision training, involving commitments of $70,000.

Short-term training, by which a measure of continuing education is provided, will continue to be supported. We anticipate supporting two such programs at a cost of $20,000 during 1967.

Individual senior clinical traineeships awarded to persons pursuing professional preparation in the field will amount to $60,000 for the support of five persons.

Programs in Vision

During 1967, project grants totaling $460,000 will be funded. In accordance with the changing goals within the Public Health Service, emphasis is placed on clinical demonstration projects which move significant research findings from the laboratory into the community. Efforts are also being made to introduce eye tests into multiphasic screening programs throughout the country.

Future Areas of Support

Along with prevention of visual impairments, the Branch is concerned that those persons already with such disabilities obtain the most appropriate and suitable medical, educational, and rehabilitative services. One of the means towards this end will be the development of new training methods and materials for the education of physicians, technical assistants, and the public in the area of vision and eye health. Another will be the development of satellite demonstration centers where research findings may be applied on a community level and where valuable epidemiological data may be obtained utilizing computer techniques for the accumulation and analysis of data.

Encouragement and financial support will be given for the development of new technological instrumentation. Meaningful efforts to apply the knowledge from basic research to combat visual disability and blindness must be accelerated wherever possible.

National Institute of Neurological Diseases and Blindness

Visual disability and blindness already can be reduced significantly by early detection and treatment. However, fundamental knowledge is still lacking in the understanding of causes and mechanisms of blinding diseases. The acquisition of this fundamental knowledge is essential to any major reduction in blindness and visual impairment. Too, since not only the eye but also the nerve pathways and the brain are necessary for vision, basic neurological research is involved.

Sight depends upon the transmission of signals along nerve pathways to the brain and upon cognitive processes. This visual process profoundly affects learning, thinking motivation, and human communication.

Any concerted attack on eye disorders necessarily includes study of the systemic disorders which may involve the eye, such as diabetes, diseases of the blood vessels, and diseases of the nerve and brain.

The incurably blind cannot benefit from either prosthetic devices, such as subnormal vision aids or drug therapy. The only recourse is to provide the people, if possible, with an electronic artificial eye. The Institute is interested in the research being conducted to further this goal and intends to support such activity.

Each step in understanding eye disorders, their nature and treatment represents solid progress toward an ultimate goal of good sight for all. As each discovery is made, however small it may seem in relation to the total problem, the goal is nearer.

During 1966, a number of significant steps were made in this direction.

THE INSTITUTE PROGRAM

The eye rsearch and training programs at the National Institute of Neurological Diseases and Blindness include research at the Bethesda laboratories, research grants to individual scientists in academic institutions throughout the country, and training grants to aid universities and other centers in educating more ophthalmologists and research scientists. In addition to individual research projects, the Institute is supporting eight multidisciplinary research programs in vision. Model Reporting Areas in 14 States provide epidemiological data. Information about the eye and its disorders is also being obtained from the Institute's collaborative and field projects, especially the Laboratory of Perinatal Physiology in Puerto Rico. These vision programs are currently operating at a level of $15 million.

Program Planning

To assist the Institute in review and planning, an Advisory Council Subcommittee on Vision and Its Disorders was organized a little over a year ago under the chairmanship of a member of the Institute's National Advisory Council. This Council Subcommittee is engaged in a general assessment of the present status of knowledge in vision and visual disorders, a review of current research and training, and identification of problem areas and special needs .

The Subcommittee is providing information gathered from the scientific community upon which the Institute can base long-term planning of its research and training program in the fields of visual science, visual disorders, and blindness. During the past year, the Council consulted with over 250 of the Nation's leading scientists to advise the Institute regarding those areas of investigation now most appropriate for intensive study.

National Information Center

To hasten dissemination of scientific information and to aid in program analysis, the Institute established this year a National Information Center on Vision Research at the Harvard University Library. Objectives of the Center are to define, identify, store, retrieve, and disseminate the literature of vision, so that the information may be communicated more quickly and completely.

This university-based unit combines the resources of a research center and one of the largest medical libraries. Within the Center, some of the Nation's outstanding scientists review and critically analyze the worldwide literature and research reports, in order to increase current awareness of research among scientists, teachers, and clinicians in ophthalmology and related fields; supervise the preparation of abstracts, summaries, reviews, and analyses of these data; and make this information available, both to the Institute for program planning and to the scientific community at large. Integration of the activities of the Center with the national network of specialized information centers, now being developed with the support of NINDB, is under way.

Conferences

The NINDB in cooperation with the American Academy of Neurology and the American Neurological Association jointly sponsored a Conference on Education in the Neurological Sciences which featured a symposium on research horizons in several areas of neuroscience, including vision, as well as round-table discussions of aspects in neuroscience education. During the year, the Institute also

sponsored a symposium on the retina and a workshop on refractive anomalies of the eye.

Program-Projects

In addition to supporting research projects related to specific problems of the blinding diseases, the Institute is now developing a group of eye research centers in which strong multidisciplinary teams are being mobilized to carry out a broad-scale attack on these disorders. Excellent studies have been reported from four of these vision program-projects now in full operation: The Retina Foundation of Boston, The Neurosensory Center at the State University of Iowa, the University of Chicago Program-Project for studies on glaucoma and disorders of the retina, and the Research Center for Corneal Disorders at Columbia University in New York. This year, with funds appropriated specifically for this purpose ,three new centers have been established at the Massachusetts Eye and Ear Infirmary in Boston, the Institute of Medical Services in San Francisco, and at the University of California in San Francisco.

Outpatient Clinical Research Units

This year, the Institute has established a new program of *outpatient* vision research units. Persons whose eye disorders do not require hospitalization are being studied in a more organized fashion by physician-scientists seeking clues to many eye problems. The new units offer opportunities for studying ocular diseases which affect only humans and cannot be duplicated in animals, and for continuing research which has reached its limits in the laboratory or in animal trials. Scientific research areas include human macular diseases, diseases of the retina, diabetic retinopathy, corneal research, herpetic keratitis, and ocular pharmacology. The first outpatient units are located at Jefferson Medical Colleg of Philadelphia, the University of Wisconsin, Duke University, New York University, the Universityof Miami, the Wills Eye Hospital and Research Institute of Philadelphia, Boston University, and Mount Sinai Hospital of New York City.

Blindness Statistics

Adequate statistics on blindness are essential to any program of prevention and control. These must be well defined and carefully assembled. At both State and national levels, this need for information includes not only total blindness but also the related degrees of severely handicapping visual impairment, both in relationship to the socioeconomic setting of each case.

The Institute has organized Model Reporting Areas for blindness in 14 States to provide urgently needed information. These areas use a common method of classification and record keeping intended to produce comparable records from each of the cooperating States. With the addition of four States this year, the project represents approximately one-third of the States and also one-third of the population of the United States. Even so, an extension of the project will be necessary before figures of national significance can be produced.

Training

The research community working in the field of vision and its disorders is proud of its record of accomplishment. However, the responsibility and challenge are enormous when compared with the small number of clinical and basic science investigators in the field. The task ahead must be contrasted with the small size of the research establishment.

NINDB-supported training programs are providing a focal point in 34 university centers for teaching and research in vision and visual disorders. However, in many of the 50 remaining schools there is no focus. To fill some of the manpower needs, the Institute proposes to establish a program of teacher-investigator awards in ophthalmology and the visual sciences. These awards will be for the support of full-time academicians in selected medical centers to promote leadership in the development of programs of undergraduate and graduate training and in the establishment of eye research programs in areas where these are lacking.

In fiscal yar 1966, 379 trainees benefited from the Institute's grants in the fields of ophthalmology, opthalmic basic science, and vision psychophysiology. Eighteen special fellowships were awarded in the areas of neuro-ophthalmology, ophthalmology, ophthalmic pathology, and sensory physiology to prepare basic and clinical scientists for careers in research and academic medicine and related fields. The Institute has given one Research Career Award on sensory physi-

ology (vision). There were 13 Research Career Development Awards and 7 post-doctoral fellowships awarded in ophthalmology and ophthalmological sciences.

RESEARCH

Glaucoma

Glaucoma is an eye disease due to increased pressure of the aqeuous fluid within the eyeball which tends to destroy the nerve cells within the retina. If untreated, it leads to impairment of vision and eventual blindness. The major emphasis of NINDB glaucoma research is toward a better understanding of the processes for maintaining proper pressure within the eye, including the early use of medications which save vision by correcting the pressure. Therefore, NINDB researchers are studying the effects of drugs on eye pressure to facilitate early diagnosis. Epidemiologists are defining the characteristics of individuals for whom special vigilance is required because they are especially prone to develop glaucoma.

It is believed that it will be possible to predict which individuals are prone to develop glaucoma because of the knowledge gained about the genetic and hereditary patterns of this disease. This represents an important advance in the field of preventive medicine. It means that we may now be able to treat patients at an early stage, thereby greatly reducing the number of people blinded by glaucoma.

This great move forward has been made possible through highly significant studies such as the Collaborative Glaucoma Study and the recently discovered steroid provocative test.

The administration of anti-inflammatory steroids was found to coincide in its effect with that of the standard water-drinking provocative glaucoma test. Minimal, moderate, and maximum responses were obtained, indicating absence or presence of glaucoma. This steroid-induced glaucoma may be the result, according to one hypothesis, of increased rate of production of aqueous humor.

In addition, much progress has been made in our understanding of the basic dynamics of intraocular pressure, and in applicable diagnostic techniques.

Community-wide screening with the aid of tonometry is making it possible to find many victims of glaucoma before the disease has advanced to a stage where vision is affected—often among people who have had no suspicion that they were affected. Continued and expanded epidemiological, genetic, laboratory, and diagnostic studies are needed, however.

In addition to patient and laboratory studies, the Institute is conducting epidemiology studies of chronic simple glaucoma in selected population groups in Pennsylvania and Arizona. Variations in tonometry techniques for measuring eye pressure have been subjected to searching evaluation. Another study of 200 pairs of twins has been established to determine genetic influences in the development of glaucoma.

Cataracts

A cataract is a clouding of the lens of the eye which interferes with normal passage of light rays to the retina.

At the present time, the only known treatment is the surgical removal of the lens. This is a relatively simple operation which has been facilitated in recent years through the use of the enzyme, alpha chymotrypsin, to loosen the lens. At the present time it is possible for even very elderly patients to undergo cataract surgery if their general health is good.

Less well known is the fact that many children are born with cataracts. They will have the best chance to see normally if surgery is performed between the ages of 6 and 18 months, according to recent research findings of NINDB grantees. If congenital cataracts are removed in late childhood, functional results are likely to be poor, these investigators found. On the other hand, the sooner the surgery, the less likely the development of irreversible changes in the eyes.

Over a period of 5 years the case for early surgery was demonstrated in studies of the visual pathways of developing kittens with cataract or artificially induced blindness. These studies demonstrated that if vision is not permitted during the early months of life, the visual pathways do not develop fully. Even though vision is later restored, the essential functional connections may never be established, and there is permanent visual impairment. A similar situation exists if a muscle imbalance occurs which prevents the two eyes from focusing on the same object. If such a squint is permitted to persist too long, the mechanism for the coordination of eye movements is severely retarded, and there is deep-rooted

impairment of the ability to develop binocular vision. Accumulated evidence suggested that children whose eyes have been similarly incoordinated since birth will have difficulty with effective binocular vision and the fusion it requires even after the incoordination is corrected.

If few binocular synapses remain in the cortex, even the most skillful balancing of extraocular muscle tensions would cause little more than cosmetic benefits. The earlier the surgery, the less likely the development of irreversible changes in the eyes. Investigators conclude that in such cases, operations between the ages of 6 and 16 months seem advisable.

Research by Institute grantees has provided valuable data on the physical and chemical properties of lens proteins. Since the formation of cataracts is associated with accumulation of insoluble proteins, these data are valuable in understanding cataracts.

Laboratory studies recently revealed the presence of the German measles virus within the cataractous lens of infants whose mothers had the disease early in pregnancy. This finding is extremely important in terms of our understanding the mode of action of this virus in producing cataracts.

Studies indicate that cystoid macular edema, or papilledema, may be present in patients whose vision fails to improve or suddenly decreases after cataract surgery. This is another problem to meet, if sight is to be saved.

Disorders of the Cornea

The cornea is a transparent membrane covering the iris or colored portion of the eye. Similar in size and structure to the crystal of a wristwatch, it acts as a protective window through which light rays pass on their way to the retina. The cornea also helps to bend and focus light rays.

Scarring produced by injury and disease causes 10 percent of the blindness in the United States and much more of the blindness in the Near and Far East. However, new drugs and improved treatments are helping to reduce the amount of this type of blindness.

Viruses.—In this country the most common cause of corneal ulcers and blindness is infection with a virus called herpes simplex, which also causes the common cold sore. One of the most significant advances in therapeutics was the discovery several years ago that herpes simplex could be cured by the drug 5-iodo-2-deoxyuridine (IDU). This was the first drug to be proved effective against any virus, and has opened up new approaches into the broader study of antiviral drugs.

Corneal Transplants.—When corneal diseases are not treated promptly, they may destroy the cornea's transparency, and cause poor vision or blindness. Fortunately it has been found possible to substitute a healthy cornea for a diseased one.

Some successful corneal transplants have been made for almost 20 years. They are usually performed with corneas taken posthumously from persons who have previously signed statements donating their eyes to eye banks. Recent Institute studies have led to improvement in transplants and in freezing and dehydrating corneas for long-range storage and shipment. This year an improved technique was developed for transplanting which may mean that some cases previously considered hopeless will regain vision.

One of the big problems with conventional transplants is that the cellular layer on the back side of the cornea—the endothelium—easily becomes damaged by a transplantation immune reaction. This results in the accumulation of fluid (edema) in the endothelium of the cornea. Such edema is rarely reversible and usually results in a cloudy graft so that the eye remains blind.

With the new procedure, a thin transparent membrane, made of silicone rubber, is sutured in back of the corneal graft. This serves as a barrier to the influx of fluid from the anterior chamber of the eye. With the insertion of the "fluid barrier," the corneal edema is reduced or eliminated and the graft has a much better chance of surviving.

The silicone rubber membrane adds support and distributes pressure from the sutures evenly over the graft, ensuring smoothness. The transparency of the silicone membrane permits inspection of the wound to observe progress of healing and formation of the anterior chamber. Local medication can be given with normal effectiveness.

While still in the experimental stage, plastic corneal implants have proved their value for a number of persons for periods of time up to 5 years.

Recent improvements in surgical techniques have greatly enhanced the prospects of success in corneal transplant operations, but graft rejection due to auto-antibodies has remained a serious problem. Certain drugs inhibit the induction and production of antibodies, but to determine which are the best drugs and what are the most desirable dosages, it is necessary to have a baseline in relation to which their powers may be tested. Until the mechanism of rejection is known, the choice of drugs must be empirical.

In a series of animal experiments, NINDB scientists augmented the intensity of the corneal graft rejections with simultaneous skin implantations from donor animals to recipients. Such recipient animals uniformly showed graft reactions with complete and sudden clouding of the grafted corneas on an average of 12 days postoperatively. This represented an earlier and more uniform reaction than had been achieved in previous efforts to establish a baseline.

Now it was possible, through a series of controlled experiments, for the investigators to demonstrate the three immuno-suppressive chemicals, namely 6-mercaptopurine—examined in a previous study—azathioprine, and corticosteroids, could delay or even suppress graft rejection in animals. The latter appeared to be the safest and most effective.

The establishment of a baseline for measuring effectiveness of suppressive drugs represents an important step in the development of agents to assure successful corneal transplant surgery.

Retinal Disorders

Although the cornea, lens, and other tissues help convey light through the eye, the actual visual process does not begin until light strikes the retina. This light-sensitive tissue at the back of the globe of the eye is the site of many disturbances which lead to visual impairment. Disorders of the retina include circulatory disturbances, injuries, inflammations, degenerations, detachments, tumors, and congenital anomalies.

Many of these disorders, especially degenerations and anomalies existing at birth, are untreatable by present-day medicine. Therefore, investigators are seeking to understand the basic anatomy and function of the retina, which they feel is necessary before treatment or prevention is possible.

Accurate understanding of retinal topography was increased this year through NINDB studies which systematically evaluated the nature of the retina in a series of eyes obtained through surgical removal and autopsy. This analysis revealed the general size and shape of the retina, the dimensions of the optic disk, and the relationship between the disk and the foveola. Through such topographical studies we shall have a better understanding of the physical and physiological characteristics of the eye.

Retinal Detachment.—Retinal detachment is a separation of the innermost layer of the eye, the retina, from the choroid, the layer just behind it. These two layers are usually in close contact; but if the retina should peel away or be pushed up from the choroid, all or part of the vision is blocked out.

Retinal detachment may be due to injury or disease. Changes that occur with age increase the chances for detachment. Persons who are nearsighted or who have had cataract operations may also be predisposed to detachment. Most detachments, however, occur for reasons unknown to medical science.

If treated early, retinal detachment may be arrested by procedures which produce an adherent scar at the point of separation. There have been important advances in the way in which this is accomplished. The retina may be burned by a sharply focused laser beam. More recently, freezing techniques (cryosurgery) are proving highly effective.

Recent advances reported in the use of retinal light coagulation indicate that certain lesions, particularly in cases of diabetic retinopathy, small fundus tumors, and lesions that lead to retinal detachment, may respond in selected cases to light coagulation. In this method, light makes a "spot weld" which, when properly directed, can be used to close off blood vessels, seal a retinal hole, anchor the retina to underlying tissue by scar formation, or necrotize ("kill") small tumors. Certain medical lesions of the fundus may be treated by light coagulation alone; in others, it is necessary to supplement the coagulation effect with heat applied to the posterior scleral surface after surgical exposure. Success with this method depends upon careful selection of patients; all cannot profit from it.

Understanding of retinal detachments was advanced by the evidence that there may be hereditary causes. There is indication of a relationship between myopia and retinal detachment. This was substantiated by a statistical analysis of 1,000 cases.

Diabetic Retinopathy.—Diabetic retinopathy is a vascular disorder of the eye which occurs in conjunction with diabetes. The condition is caused by balloon-like enlargements (aneurysms) of the capillaries supplying blood to the retina. No effective treatment is currently available. The incidence of this disorder increases with the length of time an individual has had diabetes. For example, in a series of patients who had diabetes for 15 years, 70 percent showed retinopathy, and of those who had diabetes for 25 years, 90 to 95 percent had diabetic retinopathy.

Morbidity statistics indicate that in 1934 the incidence of diabetic retinopathy among diabetics was 17.7 percent; in 1945 it was 29.6 percent; and in 1955 it was 47 percent! Diabetic eye complications are among the leading causes of blindness in the United States.

A few short years ago there was no specific treatment for diabetic retinopathy, but recently a few physicians have had success with removal of the pituitary gland in patients threatened with blindness. Preliminary results have shown improvement in visual acuity with no known harmful effects from the surgery. Nevertheless, further observations are needed before the procedure can be widely recommended.

Future studies are needed to further elucidate the mechanism of diabetic retinopathy and to develop a natural history which will make possible a more precise evaluation of present treatment methods.

A grantee study of the condition of retinal capillaries after the death of diabetic and nondiabetic patients may provide a better understanding of the disorder. Investigators found that in addition to retinal microaneurysms, diabetes is characterized by capillary sheathing and a decrease in the ratio of pericyte to endothelial cells. This blood-vessel damage is not evident in clinical examination, for by the time that capillary lesions become so gross as to be recognized clinically in the form of incipient diabetic retinopathy, the patient already has generalized diabetic microangiography (disease of the capillaries).

Retinitis Pigmentosa.—Retinitis pigmentosa is an inherited disease that usually produces its first symptom—night blindness—in childhood. Over the years peripheral vision is lost through changes which take place in the retina.

The electroretinogram and a related test, the electrooculogram, have provided very sensitive and accurate measurements of retinal damage to patients. These tests have been helpful to Institute scientists in localizing early retinal damage in the rod photoreceptors rather than in the cones.

A recent study suggests that while the light to which human beings are customarily exposed rarely produces permanent damage to normal eyes, people with inherited night blindness may benefit from wearing dark glasses when exposed to bright light. This may be particularly helpful in cases of a chronic progressive degeneration: subjective symptoms are night blindness, contraction of the field of vision, and diminution of sight.

In this study scientists found that albino rats with normal vision when kept around the clock in light of ordinary brightness developed severe night blindness after only 3 to 5 days of exposure. Given longer periods, up to 3 months, of dark adaptation afterward, these animals recovered very little of their normal sensitivity to light. The visual cells in their retinas were almost completely destroyed by several days of constant exposure to light.

Retrolental Fibroplasia.—Retrolental fibroplasia (RLF) was once common in premature infants, until it was discovered through an Institute-supported study that the ocular abnormality was related to excess oxygen consumption.

A recent study of experimental retrolental fibroplasia threw new light on the underlying mechanism of this disease which may also aid in understanding other vascular disorders of the retina. It appears that this blinding disorder may be caused by the same mechanism that produces retinitis proliferans (the late stage of diabetic retinopathy), and blindness following retinal vein occlusion.

Investigators used light and electron microscopy and histochemical techniques to study changes (hyperoxia) produced in retinas of premature kittens and other animals by excessive oxygen. Findings suggest that blood vessel proliferation (reproduction of cells and morbid cysts) following hyperoxia might be due to the liberation of some toxic substance by degenerating endothelial vessels.

Recent studies have demonstrated that full-term infants exposed to oxygen therapy are sometimes affected, too. Investigators found that the retina is not fully vascularized until shortly after birth of the full-term infant. Animal experiments have shown that the incompletely vascularized retina is susceptible to oxygen damage.

In Institute workshop planned for 1967 will discuss oxygen use in hyaline membrane disease and its potential for causing RLF.

Diseases of the Conjunctiva

The conjunctiva forms the inner lining of the lids and is contiguous with the lining of the lacrimal apparatus.

Conjunctivitis is a general term covering a number of symptomatic complaints including itching, tearing, and foreign body sensations which are not necessarily due to local conjunctival disease. Conjunctival disorders may be allergic, bacterial, or traumatic. All are inflammatory.

In a 10-year study of kerato-conjunctivitis, a research team recognized 12 distinct clinical and etiologic types of the disease. They learned that adenoviruses are the principal cause of acute follicular conjunctivitis, and herpes simplex virus the principal cause of keratitis. Keratitis and conjunctivities caused by other viruses were also studied.

Trachoma

Trachoma, a viral disease which produces scarring of the eyelids and opacification of the cornea, is a prolonged progressive disease which spreads through families and institutions, especially in depressed areas where hygiene is poor. Current World Health Organization estimates indicate that more than 400 million people throughout the world suffer from this disease. The disorder can be cured by drugs, but there is a lack of natural immunity and frequent reinfection is common.

Much more research is needed to find an effective vaccine for prevention, and therapy for permanent cure, before trachoma can be eradicated. Diagnosis of early trachoma has always been a problem. The development of an immunofluorescent technique, however, has been a major diagnostic advance.

This is an area where the ophthalmologic community can make substantial contributions toward the eradication of disease not only in a portion of our own population, but in the undeveloped areas of the world which are looking toward our technology for help.

Under the leadership of the Neurology Institute, the first broad-scale scientific survey on the prevalence, causes, and possible means of prevention of trachoma is under way in Egypt. This study of the world's most prevalent blinding disease is expected to yield a store of knowledge. A random sampling of 10,000 of 250,000 inhabitants in two large areas has now been tested for visual acuity and subjected to study, in the survey which will continue for several years.

Although trachoma blinds many people in most parts of the world (the U.S.A. is relatively free of it save among the Indians of the Southwest), Egypt was chosen for the study because trachoma occurs there in epidemic proportions.

Attempts to eradicate trachoma through mass public health programs have been successful only in the more highly developed nations. In other countries such campaigns have either failed to cure or there has been a high percentage of relapsed cases and reinfection. This is true even among Indians in southwestern U.S.

Uveitis

The underlying causes of some types of uveitis (inflammation of the iris), which strikes people in their most productive years, has been found in some cases to be toxoplasmosis, syphilis, or tuberculosis, but the cause of the majority of cases is still unknown.

Several hundred uveitis patients have been admitted to the Clinical Center for close observation and treatment with drugs. Institute scientists were among the first to discover that the infection, toxoplasmosis, is a major cause of uveitis. They concentrated their studies this year on a concerted attack on the disease with use and evaluation of a group of drugs. A new antibiotic was found to be effective when used in combination with the usual treatment for uveitis. The effects of chemotherapy on presumably toxoplasmotic uveitis and the usefulness of antimetabolite treatment on specific types of uveitis appear to hold great promise.

The role of hypersensitivity to disease-producing microorganisms or to altered tissues needs much more intensive study. Animals have been inoculated to produce similar lesions, and such studies should be continued. Extensive epidemiological studies are needed and uveitis clinics are necessary for research.

The Insitute's Collaborative Perinatal Project, which studied 60,000 pregnant women and their offspring, has revealed evidence of toxoplasmosis in 1 out of every 2,000 babies. A series of controlled epidemiological studies, to demonstrate more prescisely how this infection is transmitted, may do much toward eliminating it.

Exophthalmos

New information on the nature and treatment of dysthyroid (endocrine) exophthalmos, and recent advances in surgical treatment for the condition will bring new hope to victims of this disease, which is characterized by abnormally prominent eyeballs with lid retraction and an excessive accumulation of fluid in tissue spaces.

In two related research projects, Institute grantees succeeded in (1) establishing the site and nature of the changes which take place in ocular muscles in cases of dysthyroid exophthalmos, and (2) tested the chances of success to be expected in this disease. The investigators concluded that surgery is indicated only in the acute phase of the disease, where the cornea and optic nerve are threatened and where other measures appear inadequate.

Antithyroid drugs proved effective in one study of 129 patients whose cases were controlled over a period of years with the drugs. In none of these cases was ocular surgery required nor did the ophthalmology significantly worsen.

In cases where the medical treatment alone does not stop the progress or fails to improve the condition, X-ray therapy to the orbit has been found beneficial.

Angiographic examination (the study of blood vessels of the eye) has proved to be a safe and valuable method for establishing the nature of unilateral exophthalmos.

Various studies have demonstrated the promise in potential application of ultrasound when combined with other ophthalmologic techniques in dealing with the disease.

In one study, a basic problem in surgical correction of the severe limitation of elevation so frequently seen in the end stages of this disease was found to be the fibro-adhesive connections between the interior rectus and inferior oblique muscles and to the orbital floor. In a new method of surgery, these adhesions are separated with recession of the inferior rectus, and in some patients, recession of the medial rectus. Improvement was obtained in all cases.

Tumors

The more enlightened management of ocular neoplasms, based an better knowlelge of their biological behavior, constitutes one of the major advances that have been made in clinical ophthalmology. Refinements in diagnosis of intraocular tumors, which too often lead to serious visual loss and may also create life-endangering situations, have been achieved through long-term studies by Institute scientists and grantees. The relatively benign character of certain tumors of the uvea, conjunctiva, eyelid, orbit, and lacrimal gland has become widely appreciated and efforts are being made to develop more conservative techniques in their treatment. Other tumors are being recognized as highly malignant cancers requiring early radical surgery if the patient's life is to be saved.

As examples, characteristics of malignant tumors of the choroid may now be identified preoperatively by the use of new techniques and instrumentation. In a system developed in the ultrasonic laboratory, an ultrasonic record is produced which has the appearance of an active photograph of the diseased tissue or tumor of the eye. This facilitates recognition of characteristics of different tissues.

Radiation therapy has been reported 84 percent successful in one experimental project in initial and secondary treatment of patients with retinoblastoma (tumor of the retina). This was the first time that supervoltage irradiation had been used exclusively in a uniform manner. The project was reported after patients had been observed for a period of 6 years with no deaths and with generally useful vision.

Far more sophisticated methods of diagnosis and detection of malignant tumors of the eye are urgently needed. While the new methods, using fluorescent

dyes and radioactive tracers, appear to hold great promise, more specialized tumor diagnostic centers are needed. The lack of experimental models has hindered investigation of the basic dynamics of tumor growth and development.

Refractive Anomalies

This year, as part of its program to promote exchange of information and generate new research approaches, the Institute has supported a workshop on refractive anomalies of the eye. Considered by approximately 30 specialists from various parts of the world were such eye disorders as hyperopia, myopia, presbyopia, astigmatism, and anomalies of the accommodative and convergence mechanisms. Recommendations for further research into these eye conditions, which affect more than 90 percent of the Nation's population, were made regarding the mechanisms giving rise to the dysfunctions and diseases, diagnostic and therapeutic techniques available, and promising areas for future investigation.

In recent years, important advances have been made in the ability to correct errors of refraction, such as myopia (near-sightedness), which range from minor problems to serious involvements, some of which lead to severe visual impairment. So, too, has there been advancement in the design of instrumentation needed to exploit these new developments. Lasers, X-rays, and ultrasound have all been used successfully.

Several grantees are studying how the retina codes light impulses into electrical messages as well as how the brain decodes the message and produces the image we call vision.

Studies of the relation of the vision mechanism to perception of time, space, color, brightness, and form continue to receive support.

Institute grantees are investigating optics and refractive disorders. The use of high speed computers and ultrasound to measure different parts of the eye may lead to greater understanding of these areas. Other invesigators are studying the muscles which move the eye.

Much of the work of Institute grantees has been directed to mapping the visual impulse through the retina and various nerve pathways in the brain. The knowledge that has been gained from these studies has contributed greatly to understanding of the nervous system as well as the visual function. It has been shown, for instance, that there is an independent nerve pathway for the eye to pick up and follow roving objects.

Color Vision

Investigations have added to the information on the chemistry and other properties of the pigments in the human eye on which color vision depends. The spectra of these pigments have been determined by direct microspectrophotometry and their composition determined in part by direct regeneration experiments. Also a simple psychophysical procedure has been designed that isolates the action spectra of these pigments in living subjects. This makes it possible to measure the color vision pigments and their properties in the eyes of normal, color-blind, and color deviating subejcts. The information so obtained has implications for the genetics of inherited types of color defective vision.

Microspectrophotometric measurements upon the outer segments of the cones of primates and of fish which appear to be able to distinguish colors in the same manner as humans have explained color vision at the receptor level; these animals possess three classes of cones, each of which absorbs light maximally in a different part of the spectrum. However, electrophysiological studies in both fish and primates have shown that the different classes of receptors are not connected by separate pathways to the brain. Instead, opponent pairs of receptor types exert the antagonistic efforts of excitation and inhibition upon the retinal ganglion cells.

It has been incontestably demonstrated that topical administration of certain adrenocorticosteroids produces in some individuals an increase in intraocular pressure. Were it possible to find a drug with anti-inflammatory activity, yet free from intraocular pressure-increasing effect, the result would be both a beneficial therapeutic agent and a valuable investigative tool. Some success with such a medication, a synthetic steroid called medrysone, has been reported. Administration of this drug was not associated with rise in intraocular pressure in either glaucoma patients or normal volunteers.

A new synthetic steroid called medrysone was successfully used with glaucoma patients and normal controls. This drug has anti-inflammatory activity yet is free from the intraocular pressure-increasing effects which characterize certain

other drugs used to control glaucoma. It should be a valuable investigative tool as well as a beneficial therapeutic agent.

Because a number of drugs being used in the treatment of systemic disease may have dangerous side effects on the eye, it is important that these side effects be recognized at the earliest moment in order that blindness may be prevented. For example, chloroquine, used to treat arthritis and lupus erythematosus, produces eye damage if given in large doses over prolonged periods of time. The most serious, and irreparable damage, is that which occurs to the sensitive neural film—the retina of the eye. A simple test has now been devised to recognize this dangerous reaction in its earliest stages.

To be treated are a continual stream of individuals from all walks of life who have been exposed to an unbelievable array of toxic agents, the actions of which are only partially understood and for which we have few antidotes.

Expanded research dedicated toward the development of new and effective pharmaceuticals for the treatment of many eye disorders is of at least equal importance. It is to the national interest to develop more active programs dealing with these critical problems.

Instruments and Techniques

Increasingly, psychology and engineering are joining forces with medicine and surgery to find the answers to problems of vision. While scientists keep their sights on prevention and treatment of eye disorders, they also look forward to the day when an artificial eye may be developed, perhaps with the characteristics of a miniature TV camera, which can replace a faulty human eye. So positive are scientists that this may become a reality that definite planning is under way to lay the groundwork for this accomplishment. Meanwhile, many new instruments and techniques have been developed which are helping physicians in their treatment of patients with visual disorders.

Just recently a grantee designed and built a retinal densitometer with which he can measure in 10 seconds the amount of visual pigment upon any selected region of the human retina. With this he is measuring visual pigments, and is studying bleaching and visual function and the electrophysiology of the retina.

An instrument for measuring corneal thickness by optical means has been developed. This type of apparatus can be used on any modern slit lamp. It increases the accuracy of this type of measurement in normal corneas and those which are opaque. It practically eliminates distortions present in older instruments. It assures that the measurement is being made while observing the cornea at exactly the right angles.

A model of the retina has been developed. Electro-oculography has been developed as a technique for clinical usefulness in understanding rod and cone anatomy and connections.

Summary

As can be seen from this brief review of the field of vision, the research is extremely complex and the causes of blindness many. Unsolved problems in the field are legion, but there are many hopeful elements: great strides in research have been made in the last few years; there are now more well-trained investigators available than at any previous time; more research projects are under way than ever before; and there are more well-equipped eye research centers. This does not mean that the needs for manpower, money, and facilities have been met, but rather that research is moving in the right direction.

SOCIAL SECURITY ADMINISTRATION

The purpose of the old-age, survivors, and disability insurance program is to pay benefits to insured workers and their families when they have suffered a loss of earnings due to retirement in old age, the death of the insured worker, or a severe disability. As of June 1966, 30,000 individuals for whom blindness was a significant factor in their disability to work were receiving monthly an estimated $2,200,000 in disability benefits. (A disabling condition of the eye was the primary diagnosis in about 65 percent of these cases.) In addition, their families were receiving an estimated $400,000 monthly. It is not known how many blind persons are receiving monthly benefits as retired workers, dependents of retired workers, or survivors.

Beginning with the enactment in 1954 of the disability freeze provision of the Social Security Act, the special problems of the blind in earning a living have

been given particular recognition. The disability freeze protects a worker's future benefit rights, and the benefit rights of his family, under the Social Security program while he is unable to work because of disability. This protection is offered to those who become blind by a statutory definition even if they are still able to work. For example, a person who experiences a severe reduction in his level of earnings because of blindness can be protected from a comparable reduction in the level of monthly benefits he will receive in the future.

Through subsequent amendments to the Social Security Act, monthly disability benefits have become payable to disabled workers and their families, including the blind and their families. Special provisions in the Social Security Act reduce the work requirement for eligibility to benefits for workers who become blind between ages 21 and 31, and provide for monthly benefits for blind workers ages 55 to 64 who, although not totally disabled, are unable to do work requiring abilities comparable to those of their regular occupations.

During calendar year 1966 the Baltimore and Washington offices of the Social Security Administration employed 12 totally blind persons as dictating machine transcribers and clerk stenographers. They were trained and referred by the Maryland State Department of Vocational Rehabilitation. On an individual basis, their work performance equals or exceeds that of sighted employees.

WELFARE ADMINISTRATION

The Bureau of Family Services of the Welfare Administration administers public assistance grants to States (Title X and XVI of the Social Security Act) to assist needy blind individuals by providing financial assistance, medical care, and social services to help them deal constructively with their economic, health and social needs. All 50 States, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands have the program of Aid to the Blind (AB).

Expenditures

Total Federal, State, and local expenditures made under Titles X and XVI for the Aid to the Blind program in fiscal year 1966 were $101,466,000. Of this amount, $81,109,000 represented cash payments to recipients; $10,264,000, payments to medical vendors on behalf of AB recipients; and $10,093,000, the cost of State and local administration, services, and training associated with the program. Comparable figures for fiscal year 1965 were: total expenditures, $108,945,000; cash assistance, $86,650,000; vendor medical payments, $12,248,000; and State and local costs for administration, services, and training, $10,047,000. The Federal share of these expenditures, for all items combined, was $54,746,000 in fiscal year 1966 and $51,726,000 in fiscal year 1965. Thus, while Federal, State, and local expenditures for the Aid to the Blind program decreased between fiscal year 1966 and 1965 by $7,479,000, the Federal share increased by $3,020,000. This is due to several factors, including the more generous Federal matching available as of January 1, 1966, under the 1965 amendments to the Social Security Act.

The above data relate only to expenditures made for the blind under Title X (aid to the blind) and Title XVI (aid to the aged, blind, or disabled) of the Social Security Act; this latter title permits the State the choice of administering its adult assistance programs under individual titles or under one title, Title XVI. The expenditure data do not reflect, for fiscal year 1966, some payments made for the blind under the new Title XIX, Medical Assistance Program, enacted in the 1965 Social Security Amendments. During the period January–June, 1966, eight States and Puerto Rico adopted Title XIX and started providing medical assistance for the blind under this program rather than under the Aid to the Blind program. Data on medical assistance provided under Title XIX for the blind during this 6-month period are not available.

Caseloads and Average Payments

In fiscal year 1966, the average monthly number of AB recipients receiving money payments was 85,000, or 10,400 less than the average monthly number of 95,400 receiving payments in fiscal year 1965. Although the program has continued to decline in recent years, the large decrease between 1966 and 1965 is atypical due to the establishment, in one State, of a separate program for blind individuals not considered "needy" under the Federal Act. The decline between fiscal years 1963 and 1964 was 1,700 and between 1964 and 1965, 1,400. Average monthly payments to recipients, however, have continued to increase: in fiscal

year 1966, the amount was $81.20 compared with $75.95 in 1965, $74.00 in 1964, and $71.55 in 1963. The average vendor payment for medical care per AB recipient in fiscal year 1965 was $10.63, compared with an average of $11.72 in the first six months of fiscal year 1966. Information on medical care related solely to the blind is not available for the period beginning January 1966, when some States first adopted Title XIX Medical Assistance Programs; medical care on behalf of the blind has undoubtedly continued to improve, however, because under Title XIX States must provide high quality medical and remedial care for all persons receiving public assistance.

Eligibility

To be eligible for Aid to the Blind, Federal policy defines visual eligibility as including "persons having insufficient vision to perform tasks for which sight is essential, as well as persons without vision." In other words, visual limitation determined by ophthalmic measurement must be severe enough to result in "economic blindness." It is not necessary to be totally blind.

The blind applicant must be a needy person but there are no age limitations in the Federal Act, although a number of States have laws excluding children. Unlike the other categories, Aid to the Blind may include the whole lifespan from infancy to old age.

Public Assistance Role and Responsibilities

In addition to providing needy blind with cash assistance for basic maintenance, public assistance agencies may also provide for treatment to preserve remaining vision, for restoration of sight through surgical and medical attention whenever possible, for medically recommended optical aids to maximize use of residual vision, and for medical and dental care for other health needs.

The Federal Government will share the cost of special items related to the unique needs of the blind: a telephone, guide fees, transportation expenses, extra laundry and dry cleaning allowances, higher food expenses when the handicapped person does the cooking or must take meals in a restaurant. The food allowance for a seeing eye dog is another illustration of the flexibility that is possible.

Safe and sanitary housing is extremely important for the blind as well as safe household equipment to prevent burns and accidents. Hence, moving expenses and higher rent expenditures may be required to assure this protection for the needy blind.

The 1962 amendments encourage more comprehensive social services for the blind by providing 75 percent Federal financial participation in their costs. Forty-one States are now receiving 75 percent Federal matching for these services. To obtain this additional money, a State's services must encompass the blind who are in need for protection because of physical or mental handicaps or adverse social circumstances. There must also be provision for those who require special help to remain in their own homes or elsewhere in the community of their choice, thus avoiding unnecessary institutionalization. Similar services must be given to enable clients to return to their communities following a period of institutional care. Blind recipients with potential capacity for becoming either partially or completely selfsupporting will be assisted with plans to secure training opportunities. All of these service areas include not only the blind client but may be extended to relatives as well when their circumstances influence case planning.

Public welfare agencies collaborate with many other agencies toward the joint goal of restoration of blind people to the maximum level of health, employability, and personal satisfaction their capacities permit. By proper referral and provision of needed supportive services, the public assistance agency implements this goal so the handicaps of severe visual limitations may be mitigated or overcome. Illustrative of the foregoing: utilization of vocational rehabilitation services for young adults and those of middle age; special educational provisions for blind young people; casework services for parents of young blind children; encouragement of attendance at adjustment and mobility training centers; use of home teachers; sheltered work opportunities and community recreational resources and acquisition of talking book machines with the wide choice of records available from the Library of Congress.

For the past 6 years, the Welfare Administration has held an annual meeting for State supervising ophthalmologists associated with State AB programs in

conjunction with the annual sessions of the American Academy of Ophthalmology and Otolaryngology. This has proved to be a valuable opportunity to share information and hear about operation of the State AB agencies represented. These meetings will be continued in the future.

Cooperation with Organizations Serving the Blind

Staff continue to carry on cooperative activities with other public and private agencies, including: the Division of Services for the Blind, Vocational Rehabilitation Administration; the National Institute of Neurological Disease and Blindness, with particular interest in the development and implementation of their task of involving States in the model reporting area for blindness statistics; the National Society for the Prevention of Blindess on the use of their standard classification of causes of severe vision impairment and blindness; the American Foundation for the Blind; the American Council of the Blind; and the National Federation of the Blind.

AMERICAN PRINTING HOUSE FOR THE BLIND

This nonprofit institution, in Louisville, Kentucky, is responsible for the manufacture of special books and teaching materials which are distributed to all public educational institutions for the blind as well as to regular public schools in which blind children are enrolled.

Numbers of blind children served by the program were 18,627 in 1966; 19,250 and 19,840 are estimated for fiscal years 1967 and 1968.

Alcoholism

The conception of alcoholism as a disease entity has gained public and professional acceptance during the last two decades. Health professionals have led the way, incorporating scientific and humanistic principles into their approach to alcoholism. More recently, our judiciary has taken cognizance of this contemporary approach; courts are beginning to regard the alcoholic as a sick person in need of medical attention. This view is gratifying, for our ultimate understanding of alcohol addiction requires the contributions of the social and behavioral sciences as well as those of biological disciplines.

Alcoholism is not an all-or-none disease but one composed of many subspecies. No formal definition of alcoholism is universally applicable because the disease is defined in part by the socioeconomic context in which it occurs. Thus, the person regarded as an alcoholic in a northern industrial city may not be seen as such in an isolated rural area. With certainty, however, alcoholism, in all its subspecies is conspicuously present in virtually all socioeconomic groups in all contemporary cultures. While the reliability of our current data on alcohol-related problems is limited, certain findings suggest the extent of the overall problem.

It is estimated that there are between four and five million alcoholics in the United States. If one includes their families, perhaps 20 million people are directly affected by alcoholism. According to the World Health Organization, this country has replaced France as the nation with the world's highest incidence of alcoholism.

Only a small porportion of all alcoholics—perhaps as few as 8%—are of the so-called "Skid Row" type. The vast majority in the United States are living with their families, holding some kind of job, trying to keep a place in their communities. In 1964, some 11,000 deaths were attributed officially to alcoholism, but the actual number is believed to be far larger. Insurance companies calculate that the alcoholic's life expectancy is ten to twelve years less than that of the average person.

In some States, it is claimed that communities spend $50,000 to $100,000 in support of an alcoholic and his family during his lifetime. Costs to industry have been estimated at a minimum $2 billion a year.

Alcoholism is the number one mental health problem in nine States, according to hospital diagnoses. Of the first admissions to State and county mental hospitals in 1963, one in seven was diagnosed as alcoholic. One out of every eight male patients seen in outpatient psychiatric clinics had an alcohol-related diagnosis.

Obligations for programs on alcoholism

	1964	1965	1966	1967 estimate	1968 estimate
Vocational Rehabilitation Administration:					
Grants to States	$539,580	$791,792	$1,504,206	$2,310,400	$3,108,000
Research and demonstrations	127,000	504,000	498,000	460,000	502,000
Training and traineeships	7,000	17,000	8,000	30,000	35,000	
Innovation grants			5,000	150,000	300,000
Expansion grants			450,000	600,000	750,000
Subtotal, Vocational Rehabilitation Administration	673,580	1,312,792	2,465,206	3,550,400	4,695,000
Public Health Service:					
Health manpower education and utilization	21,870	33,908	44,867	67,105	56,875
Chronic diseases	157,800	170,000			
Urban and industrial health	24,710	69,000	79,000	184,000	500,000
National Institute of Mental Health	3,073,000	3,350,000	3,267,000	5,362,000	5,761,000
Subtotal, Public Health Service	3,277,380	3,622,908	3,390,867	5,613,105	6,317,875
Welfare Administration		17,000	143,000	129,000	129,000
Total	3,950,960	4,952,700	5,999,073	9,292,505	11,141,875

VOCATIONAL REHABILITATION ADMINISTRATION

Alcoholism is the fourth major health problem in the United States today with an estimated five million victims. About two million of these are job holders who constitute almost 3 percent of the entire industrial force. Wage losses attributed to alcoholism amount to almost 4½ million dollars a year.

In addition to the economic loss, as Secretary Gardner has pointed out, between 16 and 20 million members of families of alcoholics are tragically affected. 10,500 deaths were officially attributed to alcoholism in 1963 and there is every reason to believe that the actual number is much greater. Excessive drinking is cited as a factor in at least 30 percent of traffic deaths. Only 3 to 8 percent of alcoholics are of the so-called "skid-row" type. Experts say that more than 80 percent of all alcoholics are living with their families, holding, or trying to hold, some kind of job, trying to maintain a place in the community.

Over the years an increasing number of State vocational rehabilitation agencies have given special attention to the alcoholic. In 1966, 1,800 alcoholics were rehabilitated. There has been greatly increased activity however since the enactment of the Vocational Rehabilitation Act Amendment of 1965 (P.L. 89-333). A number of State agencies are developing special programs under Sections 3 (Innovation) and 4(a)(2)(a) (Expansion). To give some examples of State activity in this area: The Texas Division of Vocational Rehabilitation is supporting the Houston Alcoholism Rehabilitation Project, a new and comprehensive arrangement for rehabilitating alcoholic patients. The project will be conducted cooperatively with the Texas State Psychiatric Institute which in the past has had a minimal program for alcoholics. Services will be purchased by the Division of Vocational Rehabilitation from the Institute.

In Iowa the Division of Vocational Rehabilitation has embarked on a Statewide program in cooperation with the Governor's office, the Office of Economic Opportunity and a network of community resources. The State vocational rehabilitation agency will establish three transitional residential settings for alcoholics under a 3 year expansion grant. In addition the State agency has set aside $75,000 of its Basic Support funds for direct rehabilitation services to alcoholics.

In Sacramento, California, the State rehabilitation agency and the Division of Alcoholism of California's health department operate a center for alcoholics. This is a one-stop center, offering every needed service from diagnosis and detoxification through comprehensive treatment and any rehabilitation services required to get the alcoholic back to a job and a satisfactory kind of life.

The following table shows number of alcoholics rehabilitated and obligations for this program:

Fiscal year	Number	Amount
1964	782	$539,580
1965	1,136	791,792
1966	1,562	1,504,206
1967	1,900	2,310,400
1968	2,400	3,108,000

Research

Under the research and demonstration grants program authorized under Public Law 565 the Vocational Rehabilitation Administration has granted funds for 16 projects on alcoholism. Eleven of these have been completed.

Fiscal year:	*Amount*
1964	$127,000
1965	504,000
1966	498,000
1967	460,000
1968	502,000

Need for Future Research

The screening of alcoholics for rehabilitation poses a very real problem. Alcoholic individuals vary a great deal in personality characteristics. Their greatest likeness is simply the fact that they drink uncontrollably and exhibit certain symptoms caused by this condition: disturbed relationships, sense of personal inadequacy, social isolation, and instability of employment. There does appear, however, to be identifiable characteristics leading to a relatively good prognosis for rehabilitation. These relate to motivation for treatment and resources for improved social relations. So far such emerging factors have been "dryness" at time of clinic contact, sobriety during clinic interview, age (older), voluntary visit to clinic, fairly good employment history, positive family relationships, keeping of at least six clinic appointments. No doubt other characteristics predisposing to attainment of continued sobriety can be identified and developed into a structural interview to be administered during early contact.

Procedures for incorporating vocational rehabilitation into the therapy of alcoholic patients need further exploration. The first problem in this connection is the place of vocational difficulties in the adjustment of the alcoholic patient. Cause must be distinguished from effect. The spotty work history of these individuals is a symptom, not a part of the basic pathological process. Thus counseling and placement presuppose therapeutic intervention into the fundamental adjustment processes. For this reason ways must be found of integrating vocational guidance with therapy of a group or individual nature.

Training Courses for the Rehabilitation of the Alcoholics

The subject is given some attention in the two-year training grant program in the various universities receiving grants for counselor training. Some of the hospital field work programs afford an opportunity for some extensive study of the problem.

Each year a number of counselors from the State vocational rehabilitation agencies attend the Rutgers School on Alcoholism and also those held locally such as in Colorado, Utah, Louisiana, and the Southeastern Summer School in Georgia.

There is a need for an increase in intensive training activities in this area for rehabilitation personnel in all States. This staff will need greater knowledge of the pathology of alcoholism, modification of rigid and moralistic attitudes through recognizing the alcoholic's self-depreciating image, his fundamental insecurity and dependence (especially important for the welfare client). The counselor must have some understanding, too, of the needs of families of the alcoholic. Spouses and children of alcoholics have been found to benefit from group therapy which in turn benefits the entire family.

The six months internship courses for vocational rehabilitation counselors working with psychiatric cases located at Harvard School of Medicine, Harvard University, Nebraska College of Medicine, University of Nebraska, and the University of Oregon School of Medicine include lectures on alcoholism and assignment of cases presenting the problem of alcoholism.

Training grants for short-term courses on alcoholism

Fiscal year:	*Amount*
1964	$7,000
1965	17,000
1966	8,000
1967	30,000
1968	35,000

PUBLIC HEALTH SERVICE

National Center for Urban and Industrial Health

The Injury Control Program is supporting research to determine the relationship between use of alcohol and accidental injury and death; alcohol measurement; an epidemiological study relating to traffic accidents; and a study of patients admitted to hospitals to determine whether alcoholism or excessive alcohol ingestion may be a factor.

National Institute of Mental Health

Research and Demonstration Projects

An adequate conceptualization of the disease of alcohol addiction must encompass biological, behavioral, and socialogical factors. The examples cited below indicate how the National Institute of Mental Health program in support of research and demonstration studies in alcoholism fosters this broad approach.

A number of studies are in the basic sciences. One investigator has uncovered a hitherto unrecognized metabolite of alcohol. It is identified as 4-keto, 5-hydroxy hexanoic acid, and can be produced following oxidation of alcohol in various organs of experimental animals. Its significance in alcoholism is not yet clear and further work is in progress. Another scientist has shown that alcohol alone did not change concentrations of certain brain chemicals (for example, norepinephrine) believed to be important in nerve cell functioning. However, he has found that acetaldehyde, a break-down product of alcohol, produced significant changes in some of these chemicals. This work may prove to have bearing on the biochemical changes that occur in the alcoholic's central nervous system during intoxication and withdrawal.

In other work, sleep disturbances that occur as part of the clinical picture in acute alcoholic psychoses are being studied. Complex and profound disruptions of sleep have been clearly evidenced—especially those periods of sleep associated with dreaming. It has been speculated that the alcoholic's DT's might be the hallucinations of waking dreams, breaking through after years of continued dream suppression. Eventually, this type of research may further our understanding of the nature of alcoholic states—that is, what specific changes in brain activity are induced by alcohol.

In studies of factors influencing the consumption of alcohol, NIMH investigators have found that strains of mice differ substantially in the amount they will consume voluntarily. The phenomenon seems to be largely determined by the genetic-endowed ability to metabolize alcohol. Another team of investigators found that a Rhesus moneky that could work to avoid a shock drank more than an animal that had no control over the shock-producing apparatus. In this instance, it appears that the critical factor inducing drinking behavior is not so much the pain in the environment, as it is the possibility of preventing the pain, i.e., controlling the environment.

The investigators are also working with human subjects. They have found that alcohol, under certain conditions, seemed to be more of a stimulant than a depressant. Their studies indicate that continuously high levels of alcohol in blood produced little impairment in the test performance of their chronic-alcoholic subjects. The findings of another group may be related. They showed that when chronic-alcoholic subjects were given alcohol, the agent acted like an amphetamine in that it improved their performance in a test of vigilance.

In general, our fund of knowledge about how alcohol affects certain behaviors and body processes is increasing. Much more work is required, especially studies concerned with motivation for alcohol consumption and the perpetuation of problem drinking.

The treatment of alcoholism has focused on medical management of acute intoxication and withdrawal. Recent developments in pharmacology are stimulating research into new drug treatments for alcoholics. For instance, metronidazole (trade named Flagyl) is a promising compound. This drug, traditionally employed against Trichomonas infections, was discovered by chance to be potentially useful in alcoholism. A number of controlled studies of metronidazole are now underway with NIMH support. Preliminary reports suggest that it may be an effective maintenance therapy for some chronic alcoholics. These patients have said that a dose of the drug makes alcohol taste bad and makes them feel sick when they drink.

Other chemical compounds of possible potential value in the treatment of alcoholism include pangamic acid, nicotinic acid, and LSD. Russian reports have suggested that pangamic acid (sometimes called vitamin B–16), may be of use in treating chronic alcoholism. The Institute will test these claims once quantities of the drug, already under U.S. patent, are made available. It has been asserted that nicotinic acid may be useful in helping to stabilize abstinent AA members and prevent their return to drinking. However, this suggestion arose from observation of only a small number of alcoholics; the efficacy of the drug remains to be assessed. The use of LSD in the treatment of chronic alcoholic patients is presently under study by a number of investigators. Preliminary data have suggested that a variety of favorable changes occur, among them, a significant decrease in distress, an increase in insight, and an increase in the feeling of being able to cope with problems.

A number of potentially useful leads have come from a series of drug studies done in an outpatient alcohol clinic. It appears that a combination of tranquilizer plus anti-depressant was more effective than any other drug under study. This finding is consistent with theory, since alcoholics are frequently seen as suffering from both anxiety and depression. In the same series, prognosis for success of treatment was found to be related to social competency—i.e., occupational level and stability.

The complex effect of psychological and social factors on treatment outcome was shown in other studies. Improvement rate was a function of the intensity of treatment and the social adjustment of the patient. Different types of individuals appeared to do better in different treatment programs. The substantiation of this idea, which has been entertained over a period of time on the basis of scattered reports and clinical impressions, gives support to the notion that, eventually, treatment programs must be developed that are tailored specifically to serve different kinds of alcoholics.

The Institute is also concerned with exploring new settings in which the alcoholic is treated. For instance, a family service agency in Cincinnati is conducting a four-year demonstration project to develop the most effective casework services for alcoholics and their families. Few family service agencies have been willing to accept alcoholics because of the specialized treatment they require. This demonstration should provide a fund of knowledge and experience from which similar social service agencies may draw. In St. Louis, another demonstration project has developed a comprehensive community mental health center and referral service to the community's other health and social resources. This project is serving as a model for similar services elsewhere.

For a better understanding of the natural history of alcoholism, the NIMH is supporting a systematic assessment of drinking practices on a national scale. These studies focused initially on a description of normal drinking practices. Follow-up investigations are examining the factors that influence heavy drinkers to move into and out of difficulty with their drinking. The data from such studies may be useful to test a fundamental assumption in alcoholism—specifically, that heavy drinkers represent a high-risk group for later alcoholism.

The general plan of the research has been to develop methodology for the descriptive phase in San Francisco, which is regarded as a high-risk community. This work has been completed under one grant, and follow-up work is now ascertaining changes in drinking practices as well as problems associated with drinking. Results are being tested for their general applicability through the use of a national probability-based sample of the adult population.

Improving Services to the Alcoholic

As part of its program of Hospital Improvement Projects, the Institute continues to support efforts to improve services specifically directed towards alcoholic patients. In this connection, a number of grants were made recently. These awards enabled the States involved to improve the quality of treatment, and to extend services to a larger number of alcoholics than ever before. Three hospitals established special treatment units for alcoholics; these institutions now provide such services as psychotherapy, counseling for families, and vocational guidance and placement. The Spencer State Hospital in West Virginia, one of the recipient institutions, was recognized by the American Psychiatric Association for its special alcoholism treatment unit.

Five conferences were recently made possible through NIMH support—all of them with a service orientation. They were on: *The Alcoholic, the Court, and the Community* (Arizona); *Transitional Services for the Alcoholic* (Florida); *The Physician's Role in the Problem of Alcoholism* (Louisiana); *Alcoholism—Its Effect on the Social Agency* (Massachusetts); and *Interdisciplinary Efforts in the Alcoholism Field* (New Hampshire).

NIMH staff in central and regional offices continue to offer assistance to State and local groups in the planning and development of improved services as well as in all other activities in the field of alcoholism—e.g., research training, in which the Institute is involved.

Professional Training and Public Education Programs

The medical profession has a key role in treating alcoholics in doctors' offices and in hospitals. Physicans are also instrumental in promoting community understanding and interest in alcoholism. For these reasons, the NIMH is particularly active in support of training programs for general practitioners and residents in the field of alcoholism. The Institute also supports the training of other mental health professionals in the field.

For example, one project allows medical residents to learn psychodynamic principles in a comprehensive approach to all patients, including alcoholics. Additional support—to graduate schools of social work—provides for special instructional and field placement in the area of alcoholism. Another project involves the collaboration of three universities and public and voluntary agencies; it helps to prepare graduate students in social and behavioral sciences to do research in alcoholism. Students of the clergy are being trained to understand the phenomenon of alcoholism, and prepared to treat alcoholics more effectively; the project also provides for the preparation of curriculum and teaching materials that can be used in a variety of schools and settings.

Several summer institutes focusing on alcohol studies are conducted each year with NIMH support. They are attended by teachers and nurses, social workers, judges, physicians, law enforcement officials, and others. The Institute encourages the development of these courses and furnishes consultation and resource personnel to many of them. To help coordinate and intergrate teaching efforts in a difficult field such as alcoholism, a project begun in 1960 attempts to bring order to the terminology used in the field; a *Dictionary of Words About Alcohol* has been written and plans call for its publication in 1968.

With NIMH support, the American Public Health Association is completing a guide for public health control of alcoholism. It is hoped that the guide will have far-reaching effects in encouraging public and voluntary agencies to develop alcoholism services in the community. The APHA is developing plans for broad dissemination of the guide and for stimulating schools of public health to devote more attention to alcoholism problems.

The Institute's staff cooperates with other organizations of the Federal Government that are concerned with alcoholism, and maintains continuous contact with national organizations such as the American Medical Association, the National Council on Alcoholism, the American Psychiatric Association.

The Cooperative Commission on the Study of Alcoholism was established in 1960 by the Institute and the North American Association of Alcoholism Programs. Major tasks of the Commission have been to study the scientific literature in alcoholism, inventory and evaluate the programs and resources, and recommend improvements in prevention, treatment and education. The final report wll be ready for publication early in 1967 and is expected to foster new ideas and action in the field.

The National Center

The National Center for Prevention and Control of Alcoholism has been established within NIMH to coordinate the many Public Health Service activities in alcoholism, to formulate new programs, and conduct research studies in its own laboratories. The Center has begun its activities with the appointment of one of the country's leading experts in the field as chief. The general functions of the National Center are: To provide leadership in planning and developing national programs concerned with alcoholism, in collaboration with other Federal agencies, national organizations, State and local governments and voluntary citizens' groups; to coordinate NIMH research, training, and service activities in the field of alcoholism; to foster the development of a wide range of basic and applied research studies of the interrelated biochemical psychological, behavioral, clinical, and pharmacological aspects of alcohol use; to coordinate and stimulate statistical and biometric programs for epidemiological and longitudinal studies of alcoholism and alcohol use; to accelerate the application of research findings through consultation, demonstrations, field trials, and other mechanisms; to assist national, State and local organizations in improving and extending programs for the prevention of alcoholism and for the care, treatment, and rehabilitation of alcoholics; to give leadership in the development of inservice training and the continuation of postgraduate training to accelerate the use of current and new knowledge; to promote health education programs about alcohol for the general public by stimulating the development of educational materials including pamphlets, books, and audio-visual methods.

The stimulation of new comprehensive training programs will receive high priority from the new Center. A major deficit in all alcoholism programs—research, training, and service—has been the lack of trained people to carry out the many tasks. Professional training has been sadly neglected. Physicians are usually poorly prepared to handle alcohol-related problems when they meet them in their internships and residencies, and few investigators in basic science disciplines seem to appreciate the possibilities for research in alcoholism. It is reasonable to predict that future advances in our understanding and treatment of alcoholism will depend critically on supplementing and expanding current training programs for professionals. The Center will now initiate support of fellowships to provide stimulation for training personnel to engage in research and other activities in the field of alcoholism. Similarly, expansion and improvement of treatment services depend on the creation of adequate training programs for non-professionals.

A second major priority goal of the Center will be the establishment of multidisciplinary centers such as that at Rutgers University in New Jersey, the only one of its kind in the Nation. A number of these centers, located in areas with heavy endemic incidence of alcoholism, could serve to stimulate a wide range of research and service activities. The establishment of multidisciplinary alcohol research centers is both necessary and appropriate among the disease entities which can be investigated through cooperative and combined efforts of behavioral and biological scientists. Perhaps none has offered so unique a challenge as alcohol addiction. At the experimental research level a variety of new behavioral and biological techniques are available which can be imaginatively applied to alcohol research. Studies which will be carried out at the multidisciplinary alcohol research centers should greatly enhance our fund of information in the field of alcoholism and speed progress toward its prevention and control. In addition, an intramural research program is being developed at Saint Elizabeths Hospital to serve as a resource for initiating investigation of special projects in the alcoholism field.

Enactment of new health-care legislation doubtless will result in an increased demand for alcoholism-related activities. The staff of the Center is prepared to consult and work with State officials to develop such programs. Discussions have already begun with representatives of NIMH regional staff, the Department of Justice, the Welfare Administration, Office of Education, and Vocational Rehabilitation Administration. These offices will provide liaison representatives in NIMH to implement the coordination function and to help develop a joint program.

Finally, much remains to be done to improve attitudes toward alcoholism. The disease concept of alcoholism has only recently begun to overcome the social stigmatization usually associated with this illness. Attitudes held by both professionals and the general public must be modified further before significant

progress can be made in our ability to cope with the national problem of alcoholism.

WELFARE ADMINISTRATION

The Welfare Administration has continued its active interest in the field of alcoholism through a variety of research, planning, and program efforts.

Following its participation in the National Conference on Alcoholism in 1963, the Division of Research of the Office of the Commissioner undertook an extensive review of existing research, clinical practice, and organizational activities within the Federal government. In June 1966, a monograph entitled Social, Psychological, and Economic Aspects of Alcoholism was published by the Welfare Administration. This report presented an over-view and analysis of research-based social science knowledge and theory in the field of alcoholism, emphasizing, in particular, its relationship to poverty and dependency. It also suggested a future course of action and research which, in part, has formed the basis for subsequent program planning by the Welfare Administration. This publication also summarized the social science-related research and demonstration projects which were then currently being supported, and presented a brief picture of those national voluntary agencies which have major programs devoted to the social aspects of alcoholism.

More recent publications include two currently in process by the Children's Bureau. One pamphlet entitled "Straight Thinking About Drinking" is directed to teen-agers and will attempt to offer guidelines for young people in this area. It discusses social attitudes toward drinking, why some people drink and why others abstain, as well as the potential hazards of drinking. The second publication will be for parents of teen-agers and will reflect much of the same thinking as the first. Both pamphlets will be published cooperatively with the National Institute of Mental Health.

The Welfare Administration is currently funding three research projects in the field of alcoholism. Two of these projects are being conducted in Poland under the International Research Program. The first deals with the Problem of Alcoholism in an Industralized Center and is scheduled to run for three years at a cost of $37,500. This project will identify certain problems of alcoholism in an area undergoing rapid industrialization, and will also assess the extent to which the gradual stabilization of the economy affects such problems. The second project will also run for three years and concerns the Social Welfare of Children from Alcoholic Families. The cost of this project will be $74,500. This study will make comparisons between urban and rural communities and between different occupational groups in an attempt to describe which forms of welfare services are most effective for alcoholic families in meeting the needs of their children. The third project is being conducted by Stanford University with a cooperative research grant of approximately $38,000. The exploratory research is concerned with determining the relationships between use of alcohol and economic dependence, and includes pilot interviews with public assistance clients and with agency staff to determine the relative importance of alcohol in causing economic dependence.

The Welfare Administration will also sponsor a Conference on Social Aspects of Alcohol Abuse, tentatively planned for February 1967. This conference has a fourfold objective: (1) to provide national leadership in calling attention to this problem; (2) to bring together new knowledge and recent social welfare developments in the field; (3) to highlight the role of social welfare in this medical-social area; and (4) to publish conference proceedings.

The variety of programs and services to individuals and families provided by the Welfare Administration are viewed as playing a preventive role in that they seek to remove at least some of those conditions which, in all probability, serve to contribute to the incidence of alcoholism among low-income families. Undoubtedly, alcoholism is a factor in some of the cases of abuse and neglect of children found in child welfare programs. It also contributes to family breakdown, juvenile delinquency, and complicates seriously the problem of caring for and protecting many disabled and older people. While reliable estimates on the specific incidence of alcoholism among public assistance families are as yet unavailable, consideration is currently being given to collecting some information in the forthcoming 1967 Aid to Families with Dependent Children (AFDC) study.

Lastly, with the addition of a Special Consultant for Youth Services, attached to the Office of the Chief of the Children's Bureau, there has been initiated the

systematic gathering of data on the conditions of youth, which include an inventory of research regarding the extent of drinking among adolescents. This inventory will collect data on the incidence of drinking and the physical condition of the youth, as well as information on those programs which have been effective in reducing alcohol consumption.

The various activities of the Welfare Administration will continue to be closely coordinated with those of other relevant operating agencies within the Department of Health, Education, and Welfare through its participation in the work of the Secretary's Committee on Alcoholism.

Drug Addiction

The problem of drug abuse today involves a growing number of chemical compounds. The best-known drugs of high abuse potential are narcotics such as morphine or heroin, and illicit narcotics traffic flourishes in our largest cities under the conditions of poverty, cultural deprivation and social disruption. A second group is composed of the hallucinogenic compounds—"mind altering" or "psychedelic" chemicals. The best known example is LSD, whose abuse has been noted especially among college students. Although hallucinogens do not cause physical dependence, they occasionally precipitate acute psychotic reactions in users. A third group of compounds, the so-called "nice drugs" such as barbiturates and minor tranquilizers, and stimulants such as amphetamines, are also liable to abuse. Like an iceberg's bulk, hidden from sight, the latter group may be involved in the greatest incidence of drug abuse.

Obligations for programs in drug addiction

	1964	1965	1966	1967 estimate	1968 estimate
Vocational Rehabilitation Administration:					
Research and demonstrations	$94,000	.....	$148,000	$129,000	$140,000
Training and traineeships	.....	.....	18,000	30,000	30,000
Innovation grants	.....	.....	.....	200,000	500,000
Subtotal, Vocational Rehabilitation Administration	94,000	.....	166,000	359,000	670,000
Public Health Service:					
National Institute of Mental Health	7,963,356	$8,945,000	9,214,000	12,906,000	21,965,000
Welfare Administration:					
Office of Juvenile Deliquency and Youth Development	.....	247,246	211,962	[1] 44,923	(1)
Total	8,057,356	9,192,246	9,591,962	13,309,923	22,635,000

[1] Grants are awarded on a project basis. 1967 amount represents funds awarded to date. No estimate available for 1968.

VOCATIONAL REHABILITATION ADMINISTRATION

While the State vocational rehabilitation agencies stand ready to accept for vocational rehabilitation services those narcotic addicts following the maximum necessary period of treatment, few cases have been referred. Of those accepted, the number of successful closures has been minimal.

However, the 1965 Amendments to the Vocational Rehabilitation Act (Public Law 89-333) have prompted some encouraging activity in this area. The California Department of Rehabilitation is supporting a project with the Department of Corrections in Los Angeles providing rehabilitation services to residents of halfway houses operated by the Department of Corrections.

In New Jersey the New Jersey Rehabilitation Commission is supporting a project in three counties to study methods and techniques which could improve the self-image of persons who have been addicted to narcotics. Both of these are Innovation projects, under Section 3 of the Act.

In New York under the new authority whereby private funds may be matched for the establishment of rehabilitation facilities under Section 2 of the Act, the

New York Division of Vocational Rehabilitation is establishing a rehabilitation facility at Exodus House in East Harlem. This includes alterations, equipment, and initial staffing. Exodus House is a center for the resocialization of narcotic addicts.

The Vocational Rehabilitation Administration has made a grant to the Vocational Guidance Service of Houston, Texas, for the partial support of a halfway house providing intensive aftercare services for narcotic addicts released from the Public Health Service Hospital at Fort Worth. This project will demonstrate a combined hospital and post-hospital treatment program.

The Vocational Rehabilitation Administration has made a grant to Notre Dame University for a study of drug use, of the sociological and psychological factors which determine an individual's tendency toward narcotic addiction, and the resources which may be of special significance in helping him achieve rehabilitation. Part of the study will be carried out in a single block area of New York City which has a high proportion of addicts in its population.

Studies including a pilot project sponsored by the NIMH point to the need for closer coordination of community services, the fact that addicts are frequently members of families that may require as much help as the patient himself, and the need to recognize that addiction is a chronic problem and that any progress or even periodic assistance is a boost to the patient, his family, and the community. Institutionalization is not enough; ultimate rehabilitation must be accomplished in the community.

The Vocational Rehabilitation Administration will continue to encourage research and demonstration in this area. We would like to see a project on coordinated vocational rehabilitation services for addicts in the setting of a sheltered workshop, as a post-hospital experience for an addict who has had successful medical treatment.

Various new approaches were suggested in the report of the President's Advisory Commission on Narcotic and Drug Abuse. There are at present several halfway houses in operation where attempts are made to rehabilitate the addict and prevent relapse. The outpatient clinic is being considered at least from the standpoint of research studies.

Pilot efforts would have to precede any substantial efforts to build continuing projects or activities for rehabilitation of narcotic addicts into on-going State vocational rehabilitation programs. They should concentrate in the cities with greatest incidence. They should also be planned to run for at least 5 years, and then hopefully to be absorbed into on-going programs. We do not believe States can afford as yet to go extensively into so uncertain and relatively costly a venture—without Federal leadership in pilot, exploratory efforts.

Early in the planning these pilot efforts should lead into the development of special training courses for rehabilitation counselors who will handle the vocational rehabilitation of narcotics cases and others like social workers, public health nurses, probation and parole officers who will work in this rehabilitation effort.

In cooperation with the Public Health Service, the Vocational Rehabilitation Administration held a national working conference on narcotic addiction in February 1966. The main objectives of this conference were: (1) to provide factual information on the nature and extent of the problem and identify gaps in knowledge, (2) to improve communications between treatment institutions and community agencies, and (3) to develop plans for better coordination of rehabilitation efforts between community agencies.

PUBLIC HEALTH SERVICE

The National Institute of Mental Health has long been actively at work in the field of drug abuse, and now a Center for Studies of Narcotic and Drug Abuse has been established within the NIMH. The staff at the Center will coordinate the Institute's many activities in support of basic and clinical research, demonstration projects, training, community service, and information programs.

Another significant development focuses on the roles of the Ft. Worth and Lexington hospitals for the treatment of narcotic abusers. These facilities have been designated as Clinical Research Centers to serve the Institute's expanding program needs in this area. The wide range of skills and long experience characteristic of the staffs of these institutions will be critically useful in exploring many aspects of the drug abuse problem, particularly the fundamental issue of relations between drug dependency and personality disorder. The Lexington

Center will concentrate on studies in the management, treatment, rehabilitation, and aftercare of drug-dependent persons. The Ft. Worth Center will be concerned primarily with studies of the management, treatment, rehabilitation, and aftercare of persons with specific personality disorders. Both Centers will serve as models for professional personnel and others concerned with these problems.

The declaration of a new national policy on drug addiction was embodied in the Narcotic Addict Rehabilitation Act of 1966. The law provides for civil commitment of addicts charged with or convicted of Federal offenses in lieu of presecution. It also provides for civil commitment of narcotic addicts seeking treatment who are not charged with an offense, and of addicts committed for treatment by a relative. This historic measure provides for total treatment rather than fragmented efforts. For the first time, provision is made for the long-term aftercare of the postaddict patient who has returned to the community. The National Institute of Mental Health is currently consulting with other responsible agencies and formulating the plans needed to implement the new law. The Lexington and Ft. Worth hospitals will be used in the early stages of the evolving program to provide inpatient care. Outpatient facilities in several key areas are being planned to fulfill the law's authorization of aftercare supervision. As the program develops, contracts with States and communities will provide for the care and rehabilitation of addicts near their homes.

Research programs

Dimensions of the problem

There are no reliable data on the extent of drug abuse. In 1965, the Federal Bureau of Narcotics knew of approximately 60,000 individuals actively addicted to narcotics. This is believed to be a minimal number however, because it is drawn almost exclusively from reports by law enforcement agencies. Far less is known about the prevalence of non-narcotic drug abuse. One estimate is that between 200,000 and 400,000 people may be physically dependent on or habituated to non-narcotic compounds. Tranquilizers, including several with proven addiction potential, are the largest single category of drugs prescribed today. Because these compounds are readily obtainable through legitimate channels, it is especially difficult to cope with their abuse.

The Center is supporting two investigators who are beginning a national survey of drug use and attitudes towards drugs. The survey should provide basic information about the use of both prescription and illicit drugs.

A national case registry of narcotic and non-narcotic drug abusers would be a great help in defining the true dimensions of the problem. The registry also could serve as the basis for longitudinal studies of the natural history of drug abuse. Further, it could provide the first accurate body of data for evaluating treatment methods and planning new programs. It would be built from data supplied by medical, social, and law enforcement agencies. The Institute's experience with similar projects suggests that such a registry is feasible. For instance, the Institute is supporting a registry of narcotic abusers in New York City and, in contract work, a State-wide register of drug abusers is under way in Maryland.

At present, however, the NIMH does not have the necessary assurances that names reported to a national registry would be confidential. If appropriate legal safeguards can be secured, the skills and experience gained in other programs could be turned to the development of a national system.

Drugs and drug abusers

Researchers have continued to explore the pharmacology of drugs liable to abuse, the characteristics of people who abuse them, and the interactions between agents and hosts. The following examples indicate the direction of current investigations.

A group at the University of Michigan has devised a very useful animal model to study drug-seeking behavior. Movable arm-and-harness gear allows rhesus monkeys relative freedom of movement. The animals may receive intravenous injections of drugs via an indwelling catheter. They are taught to obtain drugs by pressing a bar; the experimenter also may initiate an injection. Extensive pilot work has shown that some monkeys will press the bars to obtain almost all the drugs abused by man—morphine, amphetamine, barbiturates, alcohol, and nicotine. Expanded support for this work has been given to the University of Michigan and the Southern Research Institute in Birmingham, Alabama. The

model will be used to test the abuse liability of new drugs and to study the factors influencing drug-seeking behavior in monkeys.

Next to alcohol, marihuana is the most widely used intoxicating drug in the world. Yet research on the pharmacological and behavioral effects of marihuana has proceeded slowly because adequate amounts of a chemically pure active principle were not available. A chemist recently succeeded in synthesizing the isomer of tetrahydrocannabinol that is chemically identical to the tetrahydrocannabinol isolated from natural marihuana. The Center is developing a series of studies using this new material.

Deeper understanding of the long-term effects of narcotic abuse is emerging from work at the NIMH Addiction Research Center at Lexington. A follow-up study of former narcotic addicts living in Kentucky indicates that their social adjustment is never as good after their drug experience as it was before. This is true whether or not they returned to the habit after withdrawal. The evidence tends to support the impression of many authorities that narcotic abuse leads to a deterioration in the individual's ability to meet social responsibilities. Three approaches are being used to gain further insight into the processes responsible for this postulated defect.

The first approach is based on the hypothesis that prolonged use of narcotics produces slowly reversible physiological changes in the brain. (Long-enduring physiological changes have been observed in abstinent postaddict rats.) The changes have protracted implications for the person's behavior, generally rendering him less able to adapt to environmental stresses. A study of addiction in man was undertaken at Lexington. Subjects who were addicted for a period of eight months have now been withdrawn from drugs for about four months. There is no question that the effects of withdrawal can still be seen as long as three months after the beginning of dose reduction. At the end of four months at least one physiological variable, respiratory rate, is still above the control level. It should be noted that the subjects in this study all had histories of prolonged narcotic abuse. Although they were abstinent many months prior to the study, their control values cannot be assumed to have been normal.

The second approach is based on the hypothesis that both abstinence and drug-acquisitive behavior can be conditioned. Studies of Lexington investigators extending over nearly eight years have demonstrated that one sign of abstinence can be conditioned in the rat. To date, however, the researchers have not been able to show any difference in the extent of relapse between rats that exhibit conditioned abstinence and those that do not. It seems possible that the experimental procedures are not sufficiently sensitive to pick up the phasic or short-term influences of conditioned abstinence. The work does suggest that protracted abstinence itself may be a significant cause for relapse in the rat.

The third approach starts from a concept closely related to the idea that drug-seeking behavior can be conditioned. It is assumed that addicts move in a distinctive subculture. As a consequence, certain patterns of their behavior become, in part, socially dictated and fixed. Pertinent characteristics of this subculture are learning how to "hustle" for drugs and to use narcotics intravenously. Social scientists at the Lexington Center are trying to discover how the new addict becomes involved in these processes.

More is known about the etiology and natural history of narcotic abuse than of the abuse of other compounds. Descriptive data about non-opiate drug abuse are needed to fill the gap. NIMH is supporting a series of studies of drug-use patterns. One is a study of use patterns among college students on three campuses in California. It suggests that substantial differences exist in the extent of drug abuse among the students in the various colleges. The investigator hopes to determine what shapes the decision to use drugs and how students who use drugs differ from those who do not. A pilot study has identified the characteristics of LSD users. One suggestion growing from this work was that even the "square," conventional students—football players, honor students, class officers—showed substantial tolerance for the use of drugs by others and neither condemned nor feared such use.

Another project involves a national survey of drug-use patterns in the general public. Unknown to the interviewers, some individuals who had been given tranquilizers on a prescription basis were included in the sample. The interviewers identified almost all of these people—thus indicating that it is possible through sophisticated interviewing techniques to arrive at realistic estimates of drug use. A contract has also been awarded to develop a group interview

approach to survey drug-use patterns among high school students. Similar methods have been used in studies of drinking practices.

Patterns of LSD usage are being studied more intensively. Reports have shown that most LSD is used in the Northeastern states and California. Patients hospitalized with severe LSD reactions included a fair proportion of college dropout students but almost no individuals who were still actively pursuing college studies. Adverse reactions requiring hosptialization seem to involve principally Caucasians of both sexes in their early twenties with a history of using a wide variety of drugs. Interestingly, many of these individuals had tried heroin but did not become physically dependent on the narcotic.

A study has begun of individuals known to have received LSD under medical supervision (as treatment for research purposes) 5 to 10 years ago. Individuals who have never sought or used LSD since that time will be compared with those who continued to use LSD. Any differences in psychological or social adjustment will be noted.

LSD is, of course, also being studied by several researchers to determine its effectiveness as a therapeutic agent when combined with other therapeutic methods. For example, an investigator in Iowa compared a group of sociopaths treated in part with LSD to a matched group treated by conventional methods. After a year of treatment, those LSD patients who had an intense drug reaction were doing significantly better than either matched controls or LSD patients who had shown a mild drug response. Preliminary reports from two other studies indicate that two different approaches using LSD may be more efficacious than the control treatment employed in these studies. One treatment involves short-term, hypnosis-guided psychotherapy under LSD. The second regime uses prolonged pre-drug preparation followed by 10 to 12 hours of psychotherapy under LSD.

Studies such as these indicate that LSD combined with appropriate psychotherapy may well be useful in both alcoholism and sociopathic states.

Another investigator explored the effects of LSD in a controlled, non-therapeutic setting. Volunteer graduate students received either large or small LSD doses or doses of amphetamine. The drug sessions were group experiences, conducted in an attractive artistic setting. Six months after their drug experiences, more than half of the highdose group—but almost none of those in the other groups—felt the effects had been meaningful and long-lasting. They reported an upsurge in artistic interests and enjoyment. A large battery of tests showed only scattered effects: There was some increase in calmness under stress and mild introversion but no measurable improvements in artistic judgments or creativity. Performance in graduate school was not impaired.

At present, the extent of use of marihuana is unknown. One hospital-based study shows that 5 percent of the medical patients and 15 percent of the psychiatric patients report marihuana use. The current situation is inextricably confounded by finding that multiple drug use is often reported. Almost all LSD users also use marihuana and amphetamines. About half have used barbiturates, and half have used opiates on occasion. It becomes difficult to blame given psychiatric effects, particularly chronic ones, on a single drug, although more serious reported effects appear to follow directly on LSD experience than on that of marihuana. Other studies show that some individuals use marihuana once and not again, others use it continuously, and still others go on to opiates.

Restoration of postaddicts

Until recently, treatment of narcotic abusers has consisted of humane withdrawal from drugs, and rehabilitation has been limited to psychotherapy in Federal and State institutions. New drugs and techniques are making possible pilot efforts to bring treatment and rehabilitation facilities closer to the abuser's home environment.

Testing the postaddict for evidence of relapse is an important part of outpatient programs. Methods using thin-layer chromatography to detect various drugs in urine were originally developed at the NIMH. The investigator has modified and improved the methods in grant-supported work at Boston University. Other grant-supported studies of these techniques are being done by groups in Baltimore and San Francisco. The techniques have proved to be reliably sensitive to opiates in urine. They are being employed in three States, and they seem to be valuable external controls to discourage the outpatient postaddict from relapse. Parallel studies are gradually improving methods for detecting barbiturates, amphetamines and other drugs which are abused.

One of the Center's goals is to make available rapid, inexpensive methods for monitoring urine samples routinely. These could be used in treatment programs throughout the Nation. A conference held in December 1965 was attended by all the major workers in this area. Proceedings are being published in the *NIMH Psychopharmacology Bulletin.*

Social and pharmacological approaches to treatment have been advanced also. Evidence from parole boards in New York and Philadelphia indicates that intensive parole supervision by specially trained officers substantially improves the abstinence rate and general adjustment of former heroin addicts. These programs showed better results than those observed in routine parole management of postaddicts. A project now under way in New York City compares intensive parole supervision by probation officers with an even more intensive program of support provided by social workers and public health nurses. A major issue here is to determine the relative merits of two sorts of programs: Intensive supervision by a single professional versus the collaborative supportive efforts of many medical and social agencies.

A modification of the well-known Synanon approach is being evaluated in a demonstration project at Daytop Village in Staten Island, New York. The addict must meet rigid criteria to participate in the program where he engages in intense group interactions. He gains increasing responsibility and independence as he shows improvements in behavior and attitudes.

The Ft. Worth researchers have developed a pre-release program for addicts hospitalized a long time. A month before discharge, selected patients undergo a "decompression" process. They are taken into the community, and members of the community are brought to the hospital to talk over with them some of the problems they are likely to encounter. Another experimental project of the Ft. Worth hospital provides a continuum of care for addicts of the San Antonio area. Part of the hospital's social work staff, based in San Antonio, contacts community agencies, maintains liaison with the hospital during the patient's treatment, and facilitates the patient's return to the community. Results of the program are being evaluated now.

Two new pharmacological treatment techniques are proving to be workable. In one, maintenance doses of methadone are used. This drug is a long-lasting opiate that can substitute for heroin. It relieves the craving for heroin and, in fact, blocks the pleasurable effects of heroin. Methadone maintenance doses are given narcotic abusers in conjunction with a program of social and occupational rehabilitation. Investigators at three hospitals in New York City are exploring the methadone approach; two of the groups have NIMH support.

At the Addiction Research Center in Lexington, an opiate antagonist called cyclazocine has been developed into an effective treatment drug for heroin addicts. Four milligrams of cyclazocine, taken once a day in a single dose, can block the euphoric effects of heroine for the greater part of the 24-hour period. Preliminary results indicate that some heroin addicts will accept and tolerate this treatment vountarily. An antagonist like cyclazocine with a much longer duration of action would be even more useful. The NIMH is discussing this possibility with chemists at the Winthrop Laboratories, the company that synthesized cyclazocine.

Other recent drug assessment studies made at Lexington have focused on an antagonist called naloxone (N-allyl-noroxymorphone). This compound is about ten times more potent than nalorphine. It apparently does not produce respiratory depressions, pupillary construction, or behavioral changes. Chronic administration of very large doses does not cause physical dependence. Two milligrams of this drug results in a degree of analgesia only slightly less than that produced by ten milligrams of morphine. Although naloxone may not find use as a clinical analgesic, it is an exciting compound because it suggests that the pain-relieving properties of morphine-like drugs can be almost completely dissociated from their ability to produce physical dependence.

In sum, there are a number of new treatment programs for narcotic abusers that call for careful, controlled evaluation. One of the major tasks before the Center is to develop such projects. Further, it will be necessary to improve methods for measuring the social adjustment of addicts under treatment. It seems clear that the occasional use of drugs is only one facet of the total problem. The success of any treatment program must also be measured in terms of the patient's restoration to his family and community.

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Training programs

Institute support of programs to train mental-health professionals is especially critical in the field of drug abuse. Drug abuse problems do not hold great interest for most scientists and physicians. The NIMH is especially concerned, therefore, with the training of workers who will be able to apply their skills to the special problems of drug abuse. The examples cited here suggest how this challenge is being met.

Under an Institute grant, a school of social work is using a hospital-based treatment program for narcotic abusers as a field placement for its students. Two psychiatric training grants emphasize drug abuse problems. One supports advanced training of psychiatric residents in community mental health principles. A second grant to the same institution supports basic residency training that includes a period of working with narcotic abusers in inpatient and outpatient settings. A social science training grant provides intensive training in the sociology of deviant behavior and gives instruction on drug abusers.

Another grant helps to train law enforcement officers to cope effectively and humanely with mentally ill and socially deviant persons. Training in the psychopharmacology of drug abuse and other deviant behaviors is being given to the mental health professionals who work with children in a metropolitan area.

These efforts are typical of the institute's efforts to train a large cadre of professionals skilled in the scientific and clinical issues related to drug abuse.

Development of community resources

The NIMH offers consultation in the development of research, training, and mental health project grants and provides other assistance to help communities build better mental health services for the citizens.

For example, with Institute consultation, a Hospital Improvement Program grant was awarded to the New Jersey Neuropsychiatric Institute. The grant enables the institution to implement recent legislation giving narcotic addicts the opportunity to receive hospital treatment instead of going to prison. NIMH funds have staffed an inpatient treatment center and a follow-up service at this institution. A mental health project grant supports a service center for narcotic addicts in New York City and a halfway house providing probation services for former addicts.

A construction grant for the first of 40 new comprehensive community mental health centers in New York City was awarded early in 1966. The center will serve about 200,000 people and will have a special program for drug abusers.

In 1957 the Institute began support of a five-year demonstration project in New York City. The project aimed to assist community agencies in the extension of a range of services to narcotics addicts. That study showed the need for long-term support of the patient and his family. In 1962, another five-year demonstration began to follow up these results. This project explores the potential of a local public health agency to provide continual therapy to newly probated addicts in the community.

The challenge ahead

Drug abuse is a major public health problem. We must continue to expand and integrate our efforts to counter it. We are particularly in need of more reliable information about the prevalence of non-narcotic drug abuse and more effective methods of treating these individuals. Longitudinal studies of drug abusers would enhance our ability to identify potential addicts and to improve our after programs. A major research challenge lies in understanding personality disorders and their relations with socially deviant behavior of all sorts—the chronic alcoholic, the sex offender, the violently antisocial youth, the drug abuser. The deleterious impact on society of such deviate behaviors requires that the Institute initiate bold clinical research efforts in this area.

WELFARE ADMINISTRATION

The demonstration and training grants program of the Office of Juvenile Delinquency and Youth Development of the Welfare Administration permits the Office to give financial support to projects which are innovative in approach and which, if successful, have the potential for adoption by other communities and agencies throughout the country. Three projects supported by this Office deal with the problem of drug addiction and hazardous substance abuse. One, a

program for therapeutic group work treatment with children who have become psychologically addicted to the inhalation of toxic fumes, has now refined a treatment model to utilize probation supervision and special education in the schools in order to deal more effectively with this problem. Additional data are beng collected which will provide greater insight and understanding of the underlying sociopsychological problems which lead young people to the use of addictive substances. A second project, an experimental self-help program for youthful drug users who want to cure their addiction, has produced a considerable knowledge of the confusing, frustrating and destructive environment. Funds provided by this Office supported the first national institute on amphetamine abuse. Presentations at this institute explored the social, psychological, medical, and enforcement aspects of this problem. When collated and published, this material will be used for subsequent training institutes involving education and enforcement agencies and others with direct concern for drug abuse.

Cystic Fibrosis

Cystic Fibrosis (CF) is an inherited generalized metabolic disorder characterized by an abnormality in the products of all bodily glands which secrete fluid to external body surfaces. (By medical definition the gastrointestinal and respiratory mucosa represent such external body surfaces.) These glands secrete two major types of fluid—watery sweat produced primarily by the glands of the skin, and mucus fluid intended to lubricate the bronchioles of the lung and the gastrointestinal tract. The abnormalities which occur in both these types of secretions are responsible for the clinical symptoms and signs observed which have been recognized as the distinct disease entity, cystic fibrosis, since 1938.

The basic metabolic disorder of exocrine secretion results in three principal clinical problems. First, and least disabling, is the production of sweat with a high salt content. The unique composition of the sweat has become the primary source of medical diagnosis as well. Because of this sweating defect many patients are unable to conserve salt, especially in hot weather, so that excessive sweating may lead to severe weakness and even death.

A second, and considerably more serious facet of the disease is based on the abnormality in the function of the mucus-secreting glands of the body. In cystic fibrosis, the mucus-producing glands fail to secrete their normal, clear, free-flowing fluid. Instead, they produce an abnormally thick, sticky mucus which tends to obstruct the ducts or openings of the glands. These abnormal secretions lead to a variety of serious complications. When the thick mucus accumulates in the ducts of the pancreas, it interferes with the function of this gland to supply digestive enzymes to the intestinal tract. Depending on the severity of this complication, the patient will suffer from malnutrition and its sequelae. The malnutrition of children with cystic fibrosis, combined with their repeated respiratory infections, results in general underdevelopment, poor musculature, and retarded bone growth.

The third most important complication involves the lung. Nearly all CF patients develop chronic lung disease at some time during their illness. Thick mucus deposits clog passages in the lungs or the branches of the windpipe, causing labored breathing or chronic cough. In time, bacteria may multiply in the accumulated secretions, and the child may fall victim to chronic bronchitis or even pneumonia. CF patients are extremely susceptible to lung infections and may succumb to pneumonia; lung disease accounts for 90 per cent of the deaths from this disease. Obstructed, damaged lung tissue may also impede blood circulation, and occassionally a child may die of chronic heart strain.

CF is the result of an inborn error of metabolism, inherited from parents who carry the genetic trait for the disorder. A carrier of the trait may not show any symptoms of the disease, yet is capable of passing the trait to his offspring, who, in turn, may transmit the disease. Cystic fibrosis is inherited in the active overt form when both parents carry the genetic trait. The genetic predisposition for cystic fibrosis may be passed on to the offspring of a couple if only one of the parents carries the trait. Thus for every overt case there is a large reservoir of occult carriers. As a matter of fact, this hidden affected population is reliably estimated at 2–5 per cent of the general population. Clearly, under-

standing and successful treatment of this disease would be a major public health achievement.

Although in the past cystic fibrosis was confined to the pediatric age group by its high mortality in infancy and early childhood, the disease is now recognized with increasing frequency among adolescents and adults. Recent studies have shown that there are far more adults than previously believed who carry a partial genetic endowment for the disease. The studies also have suggested that variants of cystic fibrosis may be responsible for some chronic lung and gastrointestinal disorders in adults usually not recognized as due to cystic fibrosis.

Cystic fibrosis has the highest incidence and mortality rate of any of the hereditary diseases of children. As a killer of children under 15 years it outranks poliomyelitis, rheumatic fever and diabetes combined. Its increasing frequency throughout the world has made it a public health problem of no mean proportions; estimates of its incidence in the population range as high as 1 in 1000 live births. During the past six years, 25 state departments of health have included cystic fibrosis in their crippled children's programs because of the very heavy expense for necessary and continuous care which families of afflicted children must meet.

Obligations for programs in cystic fibrosis

	1964	1965	1966	1967 estimate	1968 estimate
Public Health Service: National Institute of Arthritis and Metabolic Diseases	$961,000	$999,000	$1,040,000	$1,058,000	$1,175,000
Welfare Administration: Children's Bureau	39,480	63,725			
Total	1,000,480	1,062,725	1,040,000	1,058,000	1,175,000

PUBLIC HEALTH SERVICE

Research developments and trends

The basic defect underlying cystic fibrosis is as yet unknown and much of the research carried on by scientists of the National Institute of Arthritis and Metabolic Diseases (NIAMD) in Bethesda and by Institute grantees is devoted to discovering its nature. Institute scientists in Bethesda are currently conducting laboratory and clinical studies in an attempt to delineate further the chemical and clinical manifestations of CF and to uncover the fundamental defect responsible for the disease. Trials are also being made to ascertain the best type of treatment for the chronic lung involvement which is the major cause of death. The relationship of this disorder to other types of chronic lung disease and gastronintestinal disorders is also being explored.

In addition to the research effort in Bethesda, the Institute supports financially approximately 30 different research studies of CF at non-governmental institutions throughout the country. During the past year a number of significant findings has been reported.

New diagnostic techniques

Early diagnosis and treatment of CF are of utmost importance in order to forestall in part development of irreparable lung damage and other serious complications of the disease. At the present time CF is diagnosed principally by the detection of excessive amounts of salt in the sweat. Sweat test facilities, however, are not always readily available, and results of such tests are not always conclusive.

Last year grantee scientists at Children's Hospital Medical Center in Boston devised a new, reliable diagnostic aid for CF which involves analyzing samples of toenails, fingernails and hair for elevated concentrations of sodium and potassium. The new test also proved useful in identifying adults who are carriers of the CF trait; at present there exists no uniformly reliable method for positive identification of such individuals. Furthermore, nail and hair samples, because of their ease in collection and storage, may be forwarded by mail, thus providing ready access to specimens which may be of diagnostic or genetic interest.

Just a few months ago an engineer at Washington University, Seattle, working in close collaboration with the Boston grantees, reported that by combining nuclear reactor techniques with fingernail clippings from 170 kindergarten children he could markedly accelerate screening of such children for CF. The new test involves irradiation of nail clippings from the toes or fingers in a nuclear reactor for about an hour. The amount of sodium in the nail clippings is determined by measuring the amount of radioactive sodium produced during irradiation. Sodium levels in the nails indicate to the researchers whether or not the ranger of cystic fibrosis exists. As many as 400 specimens each day can be analyzed by this technique, as opposed to about 20 daily by conventional chemical assay. Only 0.1 mg of nail is needed for the reactor test, while the chemical method requires 200 times that amount.

These investigators believe that the importance of early diagnosis in cystic fibrosis makes the test a valuable screening procedure for all admissions to a newborn nursery. Brothers and sisters of known cases may also be examined to determine whether they are hereditary carriers of the disease, a Mendelian recessive trait.

Another investigator at the University of Nebraska has devised a diagnostic test for CF which, although somewhat less conclusive than the sweat test, may be most useful when results of other diagnostic procedures are equivocal. The new test involves microscopic examination of a sample of rectal mucosa obtained painlessly from the patient. Abnormal rectal mucus glands characteristic of CF are easily identified upon examination. Preliminary tests were performed on 24 infants and children with CF, and a positive diagnosis of CF was obtained in 16 subjects.

Newborn screening test

Half the cystic fibrosis children who receive conventional, supportive therapy are dead by age three, while one third die in their first year. When prophylactic pulmonary therapy is added, however, mortality is reduced to about two percent per year. A means of detecting cystic fibrosis in the newborn period promptly should further improve this outlook.

This past year an Institute-supported scientist reported a relatively simple, economical, and efficient sweat test for cystic fibrosis which can be applied routinely to newborn infants. Detection of cystic fibrosis in the newborn would permit earlier institution of prophylactic pulmonary therapy, thus increasing the life expectancy and decreasing the morbidity for cystic fibrosis children.

Sweating is induced by applying a heated aluminum cylinder to the infant's back for 5 minutes. The chloride content of the sweat then is measured directly by applying an electrode to the same area. Results obtained with the procedure are comparable to those obtained with a similar procedure in older children and to those obtained with conventional sweat tests. The test requires only about 10 minutes, is relatively simple to perform, and costs approximately 50 cents per infant. It is hoped that the demonstrated potential of the described procedure will speed development of standardized equipment for such a newborn nursery sweat test for cystic fibrosis.

Predicting CF

A new discovery has been made that will let couples know if their children are likely to inherit cystic fibrosis. For the first time a marker has been found in the blood of those diseased children and of parents who already have children with the disease.

It has long been known that cystic fibrosis is the result of a particular set of faulty genes in both parents. But until now no way was available of deciding accurately whether the fault was present in a potential parent or not. Now two pediatricians at Duke University, Durham, N.C., have found that when suitably concentrated blood fractions of parents of children with cystic fibrosis—those *known* to carry the genes—are placed on tissues taken from the tracheae of rabbits, then the minute eyelash-like cilia which cover the exterior of these cells and, which normally beat with a uniform wave-like sweeping motion, beat erratically and irregularly. Irregularity of beating (or sweeping) occurs also when the blood samples from children with cystic fibrosis are used. The doctors do not know what chemical component in such blood indicates the presence or possibility of transmitting cystic fibrosis, but the results are reproducible, making the test useful.

Cilia are present in the air passages in the lungs of all animals, including man. They sweep the droplets of moisture and collections of mucus in the lungs

to the foot of the trachea from where they are coughed out. Their failure to keep the lungs clear of mucus is one contributing factor to the lung congestion characteristic of CF.

Promising agent found

In a study of relationships between the sympathetic nervous system, which innervates glands, and salivary secretions, a grantee of the National Institute of Dental Research has been able to alter the chemical composition of saliva from submaxillary glands in animals and humans. He reports that guanethidine has improved temporarily the chemical balance of the components of submaxillary gland saliva in 20 children with cystic fibrosis. The cloudiness of their saliva, as compared with the clear secretion of normal children, is apparently due to an unusually high proportion of organic substances as shown by large amounts of nitrogen, and of certain enzymes and other proteins.

On the basis of the experimental circumstances, the investigator concluded that guanethidine acts directly on the submaxillary gland tissue and not through mediation of the nervous system or hormonal controls. He points out that it is the first available agent to separate two factors—the organic (nitrogen, amylase, glycoproteins) and the calcium salt components—associated with abnormal submaxillary gland saliva in cystic fibrosis. This drug may be a useful tool to determine the primary defect in cystic fibrosis. Since the organic component of external secretions plays such an important role in the pathogenesis of cystic fibrosis and since its level in the submaxillary gland saliva can be normalized by guanethidine, this agent may well be a useful research tool for further therapeutic studies.

Outlook

The genetic character of cystic fibrosis makes the disease particularly pernicious. As advances in therapy make it possible for young patients to reach the reproductive age, the "load" of cystic fibrosis traits in the genetic pool of the population will increase. If the basis genetic defect in cystic fibrosis and a method of correcting it permanently are not discovered, an ever-increasing sector of the population may find itself heir to the gene. It is this characteristic which makes continued support of effective research on cystic fibrosis an obligation to future generations.

WELFARE ADMINISTRATION

Services for children with cystic fibrosis are gradually being extended into a larger number of State crippled children's programs. In 1966, 32 crippled children's agencies reported that they accepted children with cystic fibrosis for continuing medical care. A regional medical center for the care of cystic fibrosis children, which is being supported by Children's Bureau special project funds, has been established at the University of Utah.

Since many children with chronic respiratory disease have unmet needs which are similar to children with cystic fibrosis, the Children's Bureau has been planning cooperatively with the National Cystic Fibrosis Research Foundation to broaden the services of one cystic fibrosis center as a demonstration of comprehensive care of children with any type of chronic respiratory problem.

The Children's Bureau is supporting a symposium on chest conditions in children, which includes cystic fibrosis, which will be held at Boston University in March 1967.

Cerebral Palsy

The problem

Cerebral palsy is a broad term used to describe a variety of chronic conditions in which brain damage, usually occurring at birth, impairs motor function. Cerebral palsy (CP) affects about 6 of every 1,000 liveborn infants.

Symptoms in CP may range from mild muscle incoordination to more severe physical handicaps. Impairments of motor function may involve upper or lower extremities, or both, and may affect one or both sides of the body.

Although the primary symptom in cerebral palsy is motor damage, there may or may not be other manifestations of brain damage. However, most cerebral palsied individuals show destruction of brain tissue.

The two most predominant types of the disorder are the spastic form and the athetoid type. The former is characterized by tense, contracted muscle, while

the primary symptom of the latter is involuntary and uncontrolled movements of arms and legs.

Within the constellation of associated disabilities that may occur in CP are intellectual impairment, convulsive seizures, speech defects, disorders of visions and hearing, and certain other braincentered disorders, including specific learning difficulties and behavioral abnormalities.

Neurological or sensory signs of the child's abnormal development are sometimes detected at birth but in other instances do not become apparent until months or even several years later. Early detection and diagnosis of CP in the infant or young child is crucially important in helping to prevent or lessen the extent of the handicapped effects of the disorder.

Obligations for programs in cerebral palsy

	1964	1965	1966	1967 estimate	1968 estimate
Vocational Rehabilitation Administration:					
Grants to States	$568,560	$657,968	$936,999	$1,459,200	$1,683,500
Research and demonstrations	67,000	70,000	24,000	35,000	45,000
Training and traineeships	25,000		25,000	30,000	30,000
Innovation grants	15,000	13,000	73,000	50,000	75,000
Research and training (special foreign currency program)	1,000	18,000	9,000		
Subtotal, Vocational Rehabilitation Administration	676,560	758,968	1,067,999	1,574,200	1,833,500
Public Health Service: National Institute of Neurological Diseases and Blindness	14,300,000	14,000,000	13,819,000	14,370,000	16,327,000
Total	14,976,560	14,758,968	14,886,999	15,944,200	18,160,500

VOCATIONAL REHABILITATION ADMINISTRATION

Because of the variety of handicapping conditions present in cerebral palsy, an interdisciplinary approach is particularly essential to vocational rehabilitation.

The following table indicates recent and projected trends in rehabilitating cerebral palsy clients under the State-Federal program of Vocational Rehabilitation.

Estimated and actual number of rehabilitants with cerebral palsy

Fiscal year	Persons rehabilitated [1]	
	Total	Cerebral palsy
1964	119,708	824
1965	134,859	944
1966	154,279	973
1967	190,000	1,200
1968	218,500	1,300

[1] Data are actual for fiscal years 1964–66; estimates are used for fiscal years 1967–68.

Under its basic support program, VRA has been steadily improving its efforts with the cerebral palsied. Since the determination of vocational potential of these individuals is often difficult to establish, vocational rehabilitation services may be provided under the public rehabilitation program for a period of up to eighteen months specifically for the purpose of evaluating the individual's rehabilitation capacities. Cooperative special education-vocational rehabilitation programs within the public schools have been responsible for work-study activities which have assisted large numbers of cerebral palsied young people. Throughout the country financial assistance has been provided to establish workshops sponsored by affiliates of the United Cerebral Palsy Association.

Many of the grants made by VRA to State rehabilitation agencies for the extension and improvement of rehabilitation services within a State have been in the area of cerebral palsy, frequently with the active involvement of voluntary agencies and groups. For example, a grant of this kind enabled United Cerebral

Palsy of New York City, Inc., to initiate a program of services encompassing new evaluation and training techniques for cerebral palsy cases who had been unable to achieve a satisfactory job adjustment through existing services. Related projects have been developed in Queens, New York, and Buffalo, New York.

By means of its new workshop improvement grant program, VRA has supported staff expansion and other activities to improve the United Cerebral Palsy Association of Northwest Oregon workshop in Portland, Oregon.

Under its training program, VRA has in recent years supported short-term courses such as: (1) vocational rehabilitation methods for professional staff of local affiliates of the United Cerebral Palsy Association; (2) rehabilitation counseling techniques with the cerebral palsied client for the State rehabilitation agency counselors; and (3) executive development for administrators of cerebral palsy programs. In addition, instructional content on cerebral palsy is incorporated into the various long-term professional training courses VRA sponsors at universities for rehabilitation counselors, nurses, psychiatrists, psychologists, physical therapists, occupational therapists, social workers, speech therapists, and recreation specialists.

VRA research and demonstration activities related to cerebral palsy have been varied. A project at the Institute for the Crippled and Disabled in New York was designed to develop methods of evaluating the potential abilities of severely disabled cerebral palsied adults by means of a wide variety of sample jobs. Under the sponsorship of the United Cerebral Palsy Association of Los Angeles County, Los Angeles, California, an intensive service workshop program for severely handicapped cerebral palsied adults was developed, aimed toward eventual job placement within industry. The social, psychological, and physical problems of cerebral palsied young people in college were studied under a project at the College of Education, State University of Iowa, Iowa City, Iowa. United Cerebral Palsy of New York City, Inc., has received support to develop demonstration programs to meet the vocational rehabilitation need of multiple handicapped cerebral palsied young adults and to evaluate the effectiveness of methods of training cerebral palsied adults in activities preparing them for employment or more independent living. Goodwill Industries of America, Inc., conducted a conference to explore how two nonprofit agencies may plan the cooperative use of their respective resources, in a single facility, to provide vocational rehabilitation to the cerebral palsied. Work classification and evaluation center for the cerebral palsied have been supported in centers in Milwaukee, Wisconsin; Portland, Oregon; St. Louis, Missouri; Philadelphia, Pennsylvania; Miami, Florida; Memphis, Tennessee; and Des Moines, Iowa.

PUBLIC HEALTH SERVICE

National Institute of Neurological Diseases and Blindness

Causes

The different forms of cerebral palsy are rooted in multiple causes of injury or disease of brain tissue, many of which are essentially unknown or only suspected. Some of the causes of CP occurring in the period before, during, and after birth have been identified or implicated:

Chronic or acute anoxia (oxygen deprivation) is one of the leading factors known to precede the condition of CP and other serious neurological disorders of childhood.

Rubella (German measles), contracted by the expectant mother early in pregnancy, can do serious damage to the developing nervous system of the fetus.

Obstetrical complications, such as breech birth and twin delivery, can figure in the cause of CP.

Prematurity is strongly associated with CP. The premature infant, particularly of low birth weight, is susceptible to asphyxia from respiratory distress. (Asphyxia implies not only oxygen lack but also excess carbon dioxide and other changes in blood and metabolic processes.)

Jaundice of the newborn may produce an illness called kernicterus, in which mild or severe damage of the central nervous system may occur. Most cases of kernicterus are due to incompatibility of the red blood-cell Rh factor between the developing fetus and the mother, or other blood-type conflict.

Toxemia of pregnancy, maternal diabetes, and other maternal illnesses are predisposing factors to CP in the developing fetus.

Investigation of the role of placental insufficiency in producing neurological defects has been approached in several ways. One project concerns the anesthetic, nembutal, in conferring protection to experimentally asphyxiated animals. This study revealed a remarkable difference between infant monkeys delivered by cesarean section under local anesthesia versus those delivered by cesarean section under deep nembutal anesthesia. Those delivered under local anesthesia appeared more vulnerable to the onslaught of asphyxia and showed greater incidence of neuropathological change with a given degree of asphyxiation. This important finding is being further studied.

In another project, experimental placental insufficiency resulted in an increase in the number of motor deficits in infant monkeys.

A third project linked umbilical cord compression with brain degeneration resulting in the formation within the brain of a fluid-filled sac (cyst). The degree of degeneration was well correlated with the duration of compression.

Placental abruption is known to have drastic consequences, ranging from death to the fetus to severe fetal brain damage. Until recently, little experimental work has been done on this problem. Studies of placental abruption initiated in the laboratory this past year are yielding a better understanding of pathological changes of the placenta.

The delicate and still highly preliminary techniques of intra-uterine transfusion of the fetus threatened by Rh incompatibility also occupied research attention in Institute laboratories. Previously, scientists in New Zealand devised a technique of intra-uterine injection of red cells, to replace the unborn baby's own Rh-positive cells, which were being destroyed by the anti-Rh antibodies in the mother's circulation. These antibodies cross into the placental circulation and dissolve the red blood cells of the fetus, a process called erythroblastosis fetalis.

Scientists in the Laboratory of Perinatal Physiology are attempting to determine, in animal studies, what percentage of transfused red blood cells actually reach fetal circulation following intra-uterine transfusion.

However tentative, present studies of fetal surgery may open up a chance to treat some of the blood-incompatibility problems at an early stage and prevent damage.

Other research projects.—Research into the causes, brain changes, and symptoms of cerebral palsy and related organic brain syndromes is conducted by the Institute in its laboratories and clinics, both in Bethesda and elsewhere.

Detailed histological and histochemical examinations are being made of selected brains from deceased cerebral-palsied patients to establish more exact correlations with clinical observations. This approach is expected to provide clues on possible etiology and to help in outlining management and prognosis.

Brain pathology is also receiving attention in a project involving physically produced brain damage.

Another project at Bethesda is concerned with a clinical, biochemical, genetic study of CP, to provide further evidence of the natural history of the disease.

The tools and disciplines of all the neurological sciences are being incorporated in intramural efforts to ferret out more details about the cause, diagnosis, and pathophysiology of cerebral palsy.

Treatment

Research has contributed to forestalling measures against some causes of cerebral palsy. These include blood-compatibility tests in the prenatal period, and exchange transfusion of the baby at birth, where necessary to counteract the Rh factor and other blood type incompatibility; emphasis on maintaining good maternal health during pregnancy; preventive measures—where these are now possible—against prematurity and maximum protection of the prematurely newborn against disease or infection; alertness to the dangerous consequences to the fetus of rubella and other viral infections, and a stepped-up effort to develop a safe and effective vaccine against German measles.

Meanwhile, for the hundreds of thousands of children and adults who have cerebral palsy, various forms of therapy, depending on their individual type of the disorder, can help lessen handicaps.

A combination of therapeutic measures is often prescribed, including physical and occuptional therapy, drugs in some cases to reduce muscle spasms, orthopedic surgery, special braces, and other programs involving speech and hearing therapists and other specialists in physical medicine and rehabilitation. All such

programs need to be geared to developing the individual's total capacities and remaining motor skills to the fullest extent possible.

The institute is deeply interested in the research aspects of rehabilitative therapy for brain-damaged children and adults and is participating in plans for a broad study to evaluate current therapies. At the same time it is supporting individual research projects related to treatment. For example, one project relates to the problems of the hip joint, where information is essential in the orthopedic study of the effects of cerebral palsy. Other projects relate to perceptual performance and learning abilities in children with CP, some of whom also have other forms of brain damage associated with learning problems.

Institute-supported neurosurgical teams are contributing to a more hopeful outlook for children with severely incapacitating movement disorders. These surgeons, employing stereotactic methods, are creating carefully placed lesions in certain areas of the brain.

One group of investigators has noted encouraging results of their operations on a small number of selected children, in whom all other methods of alleviating their intense symptoms (hypertonicity) had failed. Most of these children had cerebral palsy. Following surgery in the cerebellar region of the brain, the children showed a marked decrease in movement disorders, diminution of stiffness, relief of intense pain caused by muscle spasms, and in general appeared easier to care for and capable of deriving enjoyment from life. One child, who had been severely incapacitated, was able to walk and to be graduated from high school. The clinical results of this significant study were the outgrowth of years of experimental efforts to understand the interrelations of the various parts of the nervous system, particularly with respect to the motor centers which regulate movement.

Another grant-supported neurosurgical team utilized electrical stimulation to create therapeutic lesions in cerebral palsy patients. They implanted electrodes in a number of subcortical structures (striatum, thalamus, and mesencephalon) of the brain and correlated the effects of chronic stimulation in specific areas with the clinical picture. This information was then used to select the site or sites of the surgical lesion. Appreciable improvement was reported in at least one-third of the cases; the extent of improvement depended upon the area of the brain where the lesion was localized.

Research outlook

Recovery from the effects of brain damage remains one of the deepest medical challenges. Nonetheless, scientists are striving to find ways to repair injury sustained to the central nervous system and thereby provide a possible cure for cerebral palsy and other serious disorders. No one can predict when this extraordinarily complex task will be achieved. But the continuing research momentum should open the door to this possibility.

Future prevention of the causes of cerebral palsy remains as a prime target. Preventive steps for causes already discovered must be applied with vigor. The search for causes still unknown must continue unabated. Pursuit of promising leads by scientific investigators throughout the country should reap even more exciting discoveries in the future.

Muscular Dystrophy and Other Neuromuscular Diseases

The problem

More than 200,000 people in the United States are believed to have various neuromuscular disorders. Because of the slow development of certain types and the hereditary nature of many in which the carriers are unaffected, the number involved is actually considerably greater than the figure indicates. Most common neuromuscular diseases are the muscular dystrophies (MD), myasthenia gravis (MG), and the inflammatory neuromyopathies. The muscular dystrophies are particularly catastrophic to the patient and his family because the disease usually begins during childhood and progresses relentlessly. Some of the neuromuscular disorders do not shorten life expectancy but lead to disability.

Obligations for programs in muscular dystrophy and other neuromuscular diseases

	1964	1965	1966	1967 estimate	1968 estimate
Vocational Rehabilitation Administration [1]					
Public Health Service: National Institute of Neurological Diseases and Blindness	$3,700,000	$4,100,000	$3,704,000	$3,870,000	$4,378,000
Total	3,700,000	4,100,000	3,704,000	3,870,000	4,378,000

[1] No dollar amounts available.

VOCATIONAL REHABILITATION ADMINISTRATION

Progressive muscular dystrophy involves a gradual degeneration of the muscles, often marked by a displacement of muscle tissue with fatty and connective tissue. Etiology of the disease is unknown and there is no specific therapy. The disease may result in slow deterioration of the muscles, often with temporary periods of remission. Seldom a static disease, it usually results in death five to ten years after onset. Approximately 25 percent of the persons in the United States with this disease are unable to perform activities of daily living.

Relatively few individuals handicapped by progressive muscular dystrophy have been rehabilitated under the State-Federal vocational rehabilitation program. It is hoped, however, that despite the limited vocational potential characterizing this disability group, more effective rehabilitation methods will be developed which will enable greater numbers to be served by State vocational rehabilitation agencies. The VRA innovation grant program, which is emphasizing programs for individuals with particularly severe disabilities, is expected to be a primary means of extending services to this disability group.

Under its training grant program, VRA supports the training of professional personnel in the fields of nursing, social work, physical therapy, occupational therapy, and physical medicine, incorporating those skills and techniques essential to the best management of persons disabled by progressive muscular dystrophy.

VRA is also sponsoring a study of Transamidase Activity in Myotonic Dystrophy being conducted at Johns Hopkins University. Implications of this research are that it will lead to a better understanding of: Creatine metabolism in patients with myotonic dystrophy; the pathogenesis of this disorder; and the enzyme system which may be abnormal in this condition.

It may be anticipated that biochemical investigations of muscle metabolism will lead to chemical therapies which will lead to increased life expectancy and concomitant expanded opportunities for persons disabled by this disease to engage in gainful employment. When this information becomes available, VRA will use its resources to translate this knowledge into community programs of public education, case findings, physical restoration or vocational training, and placement for muscular dystrophy cases.

PUBLIC HEALTH SERVICE

National Institute of Neurological Diseases and Blindness

The various neuromuscular disorders have one feature in common—moderate or severe weakness or paralysis of muscle. Only recently has clinical and laboratory experience reached the point where accurate differentiation of the many varieties is possible. In addition to clinical examination of the patient, this differentiation requires exploitation of several newer techniques: electron microscopy—examination of the fine structure of muscle tissue; electromyography—measurement of electrical responses of muscle; tissue culture—growing muscle cells on artificial media to understand growth processes in normal and dystrophic muscle; muscle biopsy and histochemistry—microscopic and chemical study of muscle tissue; and general chemistry—study of blood and tissue chemicals and enzymes to detect generalized body chemistry alterations. Pursuit of these many approaches constitutes the Institute's main attack upon the neuromuscular diseases in an effort to define accurately the fundamental defect underlying each entity.

Muscular dystrophy (MD)

The muscular dystrophies are genetically determined disorders of muscle characterized by progressive wasting and weakness. Progressive MD (Duchenne form) occurs most often in males, beginning in childhood with limb weakness and overdevelopment of the lower legs. Facioscapulohumeral MD primarily affects face and shoulder girdle muscles, begins later, and develops less rapidly. In myotonic dystrophy, wasting appears during adolescence and is associated with stiffness and involuntary contraction of muscle. Although no treatment for MD has yet proved effective, certain drugs which influence protein metabolism are being considered for evaluation. Meanwhile, with careful clinical management, some MD patients can increase their productive lives considerably.

There are three major research approaches to the muscular dystrophies. The first is an extensive study of the mechanical and microscopic structure of the muscle itself. This includes studies into the enormous complexity of muscle tissue in both the normal and abnormal state. There are a variety of chemical substances present in the muscles and certain stains localize their distribution. These stains are especially important to demonstrating existing abnormalities of their chemical structure. This microscopic recognition of structural abnormalities within muscle cells has led to the identification of three new forms of muscular dystrophies: central core disease, nemaline myopathy, and late-onset rod myopathy. Studies have also provided a better understanding of the chemical constituents of normal and dystrophic muscle.

Another area receiving special attention is the conversion of chemical energy into the main function of the muscle, the mechanical work. The place where enzyme deficiency might show up is in its relation to energy production. This failure may not be due to an abnormality in structure but in the production of energy. Eight or nine different forms of phosphokinase deficiencies have currently been identified. Also, four disorders associated with specific enzyme deficiences have been discovered biochemically: deficiencies of phosphorylase, acid maltase, branching enzyme, and debranching enzyme. Phosphokinase deficiency affects one of the pathways for energy production in muscle. The discovery of the specific defect has led to rational methods of treatment. A study program is now being expanded in an attempt to establish whether there is a primary molecular disturbance distinct from the secondary changes that result from muscle breakdown or whether there is an environmental agent or agents functioning in addition to the primary molecular disturbance.

There is also a major study program focused on the search for abnormalities of chemicals circulating through the body. It is possible that the muscle-membrane may be deficient allowing the essential material to leak in and out. Institute grantees and other researchers have now developed diagnostic tests that rely on abnormalities of circulating substances for detecting carriers of progressive muscular dystrophy. With this technique scientists can identify 65 percent of suspected genetic carriers of progressive (Duchenne) dystrophy by measuring the amount of an enzyme, creatine phosphokinase (CPK), in the blood serum. This is providing a method for sound genetic counselling to families where the disease is suspected. A program projected for the coming year is attempting further refinement of the methods. Also, certain types of exercise that produce a significant increase in the CPK level may aid in identifying borderline carriers.

Among accomplishments this year was the demonstration of two important aspects of myotonic dystrophy: (1) a specific atrophy of the "Type I" muscle fibers; and (2) an abnormal increase in the utilization of gamma globulin. A muscle disturbance has been discovered in two protein deficiency diseases—ataxia telangiectasia and acanthocytosis.

Myasthenia gravis (MG)

In myasthenia gravis there is severe muscle weakness without wasting. Often the patient's strength is within normal range, but he develops extreme fatigue after little muscle exertion. The disorder may begin at any age, but most commonly strikes young adults. Its course is unpredictable, varying in intensity from crisis to remission. In MG, the nerve impulse is not transmitted from nerve endings in muscle, apparently because the chemical transmitter mechanisms fail. The weakness in MG patients can be ameliorated and often a life can be saved by giving them drugs which alter the chemistry of the neuromuscular transmission process.

For many years, it has been known that neuromuscular transmission depends upon the liberation at the nerve ending of a muscle excitatory substance called acetylcholine (ACH). In myasthenia gravis, this substance is either inadequate or ineffective. Drugs have been developed which enhance the activity of ACH, and thus ameliorate the symptoms. In many patients, such drugs produced marked symptomatic relief.

Myasthenia gravis is frequently, but not always, associated with tumor of the thymus gland (a gland in the chest). Removal of this gland, whether tumerous or not, appears to relieve the symptoms in some cases, but its ultimate effectiveness has been hard to evaluate due to the unpredictable course of the disease. The Institute has supported an extensive review of experiences with this surgical treatment. Improvement or complete recovery was found to occur in 89 percent of the female myasthenia gravis (MG) patients under 40 years of age when the thymus was surgically removed. These facts were obtained by evaluating 1,355 MG patients. Early surgery also eliminates the danger of malignant tumors (thymomas) of the thymas.

Recent discoveries indicate that the thymus gland plays a role in immunity. Interest in this fact is heightened by the discovery that in many patients with myasthenia gravis an antibody exists in the circulating blood with an affinity for muscle tissue. It has been postulated that in the patient with myasthenia gravis a distortion of the body's immune reaction causes the production of an antibody interfering with normal muscle chemistry.

Increasing emphasis has been placed on evaluating patients undergoing thymus surgery for the relationship between the level of antimuscle antibodies and serum complement (C′), with the change in clinical condition. Also, further investigation is focused on the manner in which circulating antimuscle antibodies may disrupt physiological mechanisms in the post junctional membrane (pjm) of the neuromuscular junction. The importance of the pjm has recently gained additional emphasis by studies into the blocking effect of the anesthetic, halothane, recently favored with patients suffering neuromuscular disorders. Desensitization of the pjm was found to be the major factor in its effectiveness.

Some further support for the role of autoimmunity in myasthenia gravis is the action of ACTH, a drug known to suppress immune responses an inflammation. Its usefulness in myasthenia gravis has been a source of great controversy. An Institute-sponsored study carried out in 1964 indicated that small doses of the drug in mild cases were ineffective. This year, further studies reveal that larger doses may provide at least a transitory benefit in carefully selected severe cases.

Other neuromuscular diseases

Major disability or muscular weakness also results from the periodic paralyses, dermatomyositis, and cancer-associated neuromuscular diseases.

The periodic paralyses are characterized by transient episodes of severe muscle weakness, and are associated with abnormalities in the amount of potassium circulating in the blood. These inherited disorders are now accurately classified and remarkably well controlled. In cases where the cause is associated with thyrotoxicosis, a cure is usually possible by removal of the thyroid gland.

Dermatomyositis includes chronic inflammatory diseases of muscle which lead to painful stiffening and eventual incapacity. While an infectious origin is suspected, specific agents have not been found for the majority of forms. Dermatomyositis may begin at any age and is usually progressive if untreated. Recent discoveries are provided a cure for some of the cases.

Certain forms of cancer produce changes in body chemistry and cause disorders of muscle which closely resemble the dystrophies and dermatomyositis. Often the cancerous origin of the muscle disease does not appear in a recognized form.

Important developments are being made in the understanding and control of these disorders. Current studies on dermatomyositis are attempting to determine the actual sensitivity and to modify the effects. Also findings concerning remote cancer as a cause of late-onset neuromyopathy and its sex-related incidence are aiding in providing important diagnostic leads for physicians. The nature of the process by which the cancer induces myopathy continues to be the subject of intensive Institute-supported research. And because genetics is fast becoming an important discipline in the study and prevention of many of these other inherited neuromuscular disorders, efforts are being concentrated on developing additional genetic screening tests similar to the CPK assay for detecting carriers of progressive muscular dystrophies.

Program developments and future plans

The Institute's research program relating to neuromuscular disorders includes support of individual investigations and the training of clinical investigators in basic neurophysiology and neurochemistry techniques. With the availability of more personnel trained in basic and clinical neurological research, an expansion of the Institute's programs in this area will be possible.

Because the understanding of complex diseases requires a multidisciplinary approach, the study of neuromuscular disorders has been an important segment of the Institute's research program at its Bethesda laboratories. Upon completion of the new NINDB-NIMH research building, increased space and facilities will be available for neuromuscular disease studies.

Plans for broadening the Institute's attack on neuromuscular disease include support of clinical research centers specializing in the neuromuscular diseases, a drug evaluation program, development of effective screening methods to detect persons with inherited neuromuscular and other neurological disorders, and support of scientific communication through publications and conferences.

Clinical research centers.—Two university-based clinical research centers concentrating on the study of neuromuscular diseases have been established with Institute support at the University of Pennsylvania and at Columbia University. The Institute supports a large research and training center on the physiology of muscle at Harvard and underwrites a similar basic science unit at Columbia, concentrating on chemical aspects of neuromuscular transmission. One additional research center in the neuromuscular diseases will be supported next year. In the research centers, scientists representing many disciplines have been brought together to focus their combined skills on basic and clinical research in the varied aspects of the neuromuscular system in health and disease.

To further strengthen its program, the Institute has developed under the P.L. 480 program, a collaborative project at the Academy of Medicine, Warsaw, Poland. The clinic in Warsaw has been designated as a center to which neuromuscular disease patients from the entire country are referred. Scientists there are developing competence in electron microscopy, histochemistry, and general chemistry methods to parallel and complement studies in progress in Bethesda. Exchange of scientists furthers this effective collaboration. The Institute plans to support similar collaborative studies at other medical centers. For example, scientists at the center at Columbia and in Yugoslavia have a common interest and capability for the study of the mechanism and chemistry of neuromuscular transmission.

Drug evaluation.—Effective drug therapy for the neuromuscular diseases remains a major need. The Institute has encouraged improved methods of drug evaluation through its clinical neurological centers, and some success with new chemotherapeutic agents has been achieved in this program. For example, Institute physicians have helped to clarify the criteria and methods of use of corticosteroids in treating collagen-vascular diseases—neuromyopathies affecting nerve, muscle, blood vessels, and connecting tissue.

In the evaluation of therapy of myasthenia gravis, the Institute in collaboration with the Myasthenia Gravis Foundation conducted a study of ACTH in ocular myasthenia and a grantee reviewed thymectomy for treatment of MG. The Institute is now supporting development of methods for evaluating muscular dystrophy therapy.

Publications and conferences.—Institute scientists have prepared a monograph on "Current Concepts of the Myopathies," and recently have written chapters on the tissue chemistry of neuromuscular disease in six monographs.

Two major international scientific meetings, in which the Institute has had an important part, have been the international symposium on "Exploratory Concepts in Muscular Dystrophy and Related Disorders" organized by the Muscular Dystrophy Associations of America, and the conference on "Experimental Myopathies and Their Relationship in Human Muscle Disease" called by the New York Academy of Sciences. Important new developments were reported and major goals and needs were identified, the most urgent appearing to lie in a closer link between the hospital and the theoretical laboratory in making material and findings more readily available. Other specialized conferences, designed to stimulate scientific communication among experts in the neuromuscular field, also have included the following topics: "Biophysics of Excitable Membranes," "Mutant Mice with Neurological Diseases," and "Myasthenia Gravis."

Multiple Sclerosis

The problem

It is estimated that approximately 500,000 Americans are afflicted with multiple sclerosis (MS) and such closely related disorders as amyotrophic lateral sclerosis (ALS), spinal muscular atrophy, and allergic encephalitis.

Multiple sclerosis, the most common of this group of disorders, is a major disease of the central nervous system, in which myelin, the fatty, protective tissue sheathing the nerve fibers, disappears in scattered patches. It afflicts more than a quarter of a million Amercians, primarily between the ages of 20 and 40 years.

The disorder, chronically progressive in the majority of affected persons, proceeds in a series of unpredictable attacks. In earlier stages, attacks are often followed by periods of remission. With successive episodes, resulting lesions in the brain and spinal cord become more dense and destructive, causing more severe disability.

Geographically, the incidence increases as the temperature of the climate declines. In the northern States, its incidence is 40 to 50 per 100,000 population, while in the South the number of cases drops to as low as 10 to 15 per 100,000 population.

The causes of multiple sclerosis and mechanisms by which the disease is produced are both unknown. Despite the increase in basic research information, no dependable treatment to ameliorate or specific therapy to counteract the disease has become available.

Amyotrophic lateral sclerosis, another member of this family of disorders, is of particular research interest because of its geographic distribution. Although comparatively rare, this disease is prevalent on the island of Guam and certain of the nearby Marianas, where a form of ALS is over 100 times more common considering the size of the population than in the continental United States. This unique situation provides an opportunity to search for specific causative agents that may be responsible for producing the disease.

Obligations for programs in multiple sclerosis

	1964	1965	1966	1967 estimate	1968 estimate
Vocational Rehabilitation Administration: grants to States	$166,980	$173,553	$259,047	$486,400	$647,500
Public Health Service: National Institute of Neurological Diseases and Blindness	2,800,000	3,000,000	3,019,000	3,897,000	4,387,000
Total	2,966,980	3,173,553	3,278,047	4,383,400	5,034,500

VOCATIONAL REHABILITATION ADMINISTRATION

Accomplishments

1. Federal-State program

Estimated and actual number of rehabilitants with multiple sclerosis [1]

Fiscal year ending June 30—	Persons rehabilitated	
	Total	Multiple sclerosis
Fiscal year ending June 30—		
1964	119,708	242
1965	134,859	249
1966	154,279	269
1967	190,000	400
1968	218,500	500

[1] The total number of rehabilitants is actual for fiscal years 1964, 1965, and 1966; for fiscal years 1967 and 1968 they are estimated on the basis of State budget estimates and Federal funds requests. The number of rehabilitants disabled by multiple sclerosis are actual for fiscal years 1964 and 1965; for fiscal years 1966, 1967 and 1968 they are estimated on the basis of the proportion in the group for the preceding 5-year period.

Because multiple sclerosis is a progressive disease, forecasting employability for these individuals is difficult and unpredictable. For this reason, State rehabilitation programs often have not undertaken services for larger numbers of this disability group. In fiscal years 1967 and 1968 an estimated total of 900 persons handicapped by multiple sclerosis will be rehabilitated.

2. Training

There have been no specific training programs sponsored by the Vocational Rehabilitation Administration for multiple sclerosis. However, instruction about a number of neurological diseases is incorporated into the basic training program for a number of professional personnel such as rehabilitation counselors, nurses, psychiatrists, physical therapists, and occupational therapists.

3. Research

One research project was funded in 1965 to Georgetown University, Washington, D.C., with Desmond S. O'Doherty, M.D., Project Director, with an anticipated duration of three years. The brief description of the project purpose is: "To establish a model program in the rehabilitation of mulitple sclerosis patients and establish predictive factors for the disease."

Research and training needs

1. Rehabilitation research needs

(a) The study of various physical modalities used in physical medicine in the treatment of multiple sclerosis.
(b) The use of orthotic devices.
(c) The causes and treatment of spasticity.
(d) The causes and treatment of contractures and other complications.
(e) The therapeutic uses of various forms of heat to reduce symptoms.
(f) The use of activities of daily living techniques.
(g) Homemaking programs.
(h) Psychological and psychiatric evaluation and treatment of this condition.
(i) The use of various aids in increasing the vocational potential of these patients.

2. Training needs

The basic need is that of trained personnel to treat, study, and to train patients with multiple sclerosis. These would fall in the category of physiatrists, physical therapists, occupational therapists, psychiatrists, psychologists, counselors, homemakers, nurses, speech therapists, and other related personnel.

Prospects for the future

With further advances in drug therapy, neurosurgical procedures, and rehabilitation techniques, the potential of those suffering with multiple sclerosis should be much greater than at present. It is our plan to encourage further research and training programs as well as the educational aspects of this disease. Since the larger proportion of persons with multiple sclerosis are women in the 20 to 40 age group, the objective should be to accept increasing numbers for services with the vocational goal of homemaker.

PUBLIC HEALTH SERVICE

National Institute of Neurological Diseases and Blindness

Research approaches

The studies in MS have been directed mainly to understanding the biochemistry of the disease, its geographic distribution, and its possible relation to allergic encephalitis and viruses.

Of the four major research approaches to MS, *epidemiology of the disease* was probably the first to be extensively investigated. This is the science dealing with the relationships of the various factors which determine the frequencies and distributions of disease in a population.

Multiple sclerosis is confined almost entirely to regions having a temperate or cold climate. It is many times more prevalent in Canada or northern United States than in the southern areas of this country, and almost unknown in the tropics. Institute-supported studies in the U.S.A. and around the world have amply confirmed this important clue. Even more important, studies of afflicted soldiers have demonstrated that it is the climate within which one has spent

one's childhood, and not where one is living when the disease manifests itself, that is important.

In Israel, a study of MS patients has not only confirmed the higher prevalence of this disorder in immigrants from temperate latitudes but has also indicated that the onset of the disorder may be as long as 10 to 15 years after leaving the temperate climate for the subtropical area. Data to support this conclusion are found in the incidence rates which are much higher in Europeans immigrating between the ages of 15 and 29 than in the youngest age group, those less than 15 years old. These data suggest that multiple sclerosis is acquired, at least in many cases, before age 15 years. However, it is unlikely that the disease is acquired at birth or in early infancy since migration from Europe to Israel before age 15 years appeared to have had a protective effect.

These epidemiological evidences are receiving further study to determine what other social or environmental factors are operative. Preliminary data suggest that the more favored socio-economic groups may be particularly susceptible. In a study of 1,000 U.S. veterans which the Institute is conducting with the Veterans Administration and the National Research Council, it has been found that a larger number of veterans from the cities have multiple sclerosis than those from the rural areas. It was also found that men and women with higher education and earning power are most susceptible to the disease.

The study of viruses is a second approach. One possible explanation for the long latency and the recurrent nature of the disease is a slow or latent virus infection. Viruses have been under suspicion and have been investigated as a possible cause for this disease for many years. Viruses could cause the disease by damaging the nervous system and by liberating a fraction of the very complex protein and lipid material that make up the nervous tissue. The demonstration that viruses may lie dormant in the nervous system for long periods of time in other diseases, such as herpes simplex and the disease of sheep called scrapie, lends support to this possibility.

This year this thesis has received additional support through the discovery of an agent transmitted to chimpanzees from patients suffering from a mysterious degenerative disease called kuru. The condition bears some resemblances to multiple sclerosis, and suggests that MS may have a similar basis. This research was conductd at a special virus laboratory established by the Institute at Patuxtent, Maryland, in cooperation with the Fish and Wildlife Service, Department of the Interior. Here material from patients suffering not only from kuru but from multiple sclerosis, amyotrophic lateral sclerosis, and related diseases is being injected into primates and other animals in the search for a transmissible agent. For the development of this study, a considerable number of animals will have to be retained in absolute isolation for from 5 to 10 years following inoculation.

In a closely related study partially supported by the National Multiple Sclerosis Society, serum from patients with multiple sclerosis is being tested for antibodies against a number of the common viral diseases. It is postulated that these common diseases may occasionally produce MS as an atypical reaction to the virus. Possibly such a virus reacts with brain tissue to initiate an autoimmune reaction as described below.

Another major research effort is being directed toward understanding *the biochemistry of the disease*. A characteristic feature of MS is liquefaction of the fatty sheath surrounding the nerves. One focus of the Institute's program has been on the chemical processes involved in the formation and destruction of this fatty sheath, called myelin. It is possible that a nutritional or toxic factor might be responsible for this tissue breakdown.

Experimental demyelination is a fourth approach to the study of MS. Since liquefaction of myelin is a characteristic feature of MS, the experimental production in animals of such a reaction is an important research tool. One means whereby this can be accomplished is through experimental allergic encephalitis (EAE). Normally, the body's protective immunity is directed only toward the destruction of foreign substances or germs introduced into it from outside. Under certain abnormal circumstances, the body may direct its immune defenses against its own tissues. Thus, if specially prepared brain extracts are injected into an animal, the animal's immune defenses are mobilized and attack the animal's own brain tissues. Demyelinization bearing many resemblances to MS may result. The belief that such a mechanism may be operative in MS has been strengthened by the observation that, when serum from patients with MS is applied to nerve cells in tissue culture, liquefaction of the myelin sheath

occurs. The study of nerve growth in tissue culture, and the reactions of this tissue to antiserum, toxic agents, and drugs is therefore important in the study of MS.

Although anti-myelin antibodies have thus been demonstrated in the blood serum, there is evidence to suggest that the circulating blood cells (lymphocytes) may play an essential role in antibody production and in the autoimmune process, because lymphocytes produce most antibodies. Over-reactivity of the lymphocytes in patients with multiple sclerosis was recently suggested from studies in which lymphocytes from patients and controls have been caused to interact with spinal fluid. Changes in the lymphocytes called transformations occurred more commonly in the MS patients. This test may prove to be a useful diagnostic tool.

Additional studies are now seeking to determine the specific brain substance (probably protein) to which the body becomes sensitized, the tissues within the body through which the antibodies are produced, the structures in the brain which are specifically attacked by the autoimmune process, and most important, the means whereby such an autoimmune process can be blocked.

An agent known to reduce the body's immune responses is ACTH. It has been suggested that this drug could be useful in reducing the severity of attacks of MS. To test this possibility, the Institute has organized a cooperative therapeutic trial to determine whether ACTH is effective in treating the relapses of MS.

It is now becoming evident that MS is a well-defined disease entity. The consequence of its destructive process in the brain is specific. Some characteristics of the causative agent or factor, and the details of the course of the disease have been outlined. The Institute now has a well-rounded program, involving its intramural laboratories at Bethesda, and many independent scientists in laboratories across the country. Within these laboratories studies focused on the key problems relating to this mysterious disease are in full progress.

Speech and Hearing

Obligations fiscal year 1964 to fiscal year 1968

Agency and program	1964	1965	1966	1967	1968
Vocational Rehabilitation Administration:					
Grants to States	$6,070,620	$6,774,840	$10,246,320	$16,416,000	$19,813,500
Research and demonstrations	294,000	398,000	365,000	515,000	473,000
Research and training centers			100,000	100,000	250,000
Training and traineeships	2,795,000	3,495,000	3,772,000	4,630,000	4,100,000
Innovation grants	45,000	112,000	112,000	100,000	100,000
Expansion grants			235,000	250,000	300,000
Foreign currency program		153,000	233,000	342,000	182,000
Subtotal, Vocational Rehabilitation Administration	9,204,620	10,932,840	15,063,320	21,753,000	25,218,500
Office of Education:					
Educational improvement for the handicapped	3,533,854	3,774,973	5,275,505	6,270,000	[1] 6,270,000
Elementary and secondary education—title III			1,086,341	1,890,000	3,500,000
Captioned films for the deaf	1,384,000	1,380,695	2,797,591	2,800,000	2,800,000
Educational improvement for the handicapped—research	64,340	210,703	609,330	613,000	1,200,000
Research and training	364,112	214,650	267,607	275,242	206,468
NDEA—title VII—Educational media research	47,236	319,985	203,955	81,836	50,000
Subtotal, Office of Education	5,393,542	5,901,006	10,240,329	11,930,078	14,026,468
Public Health Service:					
Chronic diseases and health of the aged	1,169,679	1,341,000	1,344,060	1,644,000	100,000
National Institute of Neurological Diseases and Blindness	8,117,000	8,911,000	10,783,000	11,787,000	13,453,000
Subtotal, Public Health Service	9,286,679	10,252,000	12,127,060	13,431,000	13,553,000

[1] Not including funds authorized under title VI of Public Law 89-10, as amended by Public Law 89-750.

Obligations fiscal year 1964 to fiscal year 1968—Continued

Agency and program	1964	1965	1966	1967	1968
Welfare Administration:					
Children's Bureau: Salaries and expenses	$19,013	$20,763	$28,123	$43,278	$43,500
Special project grants	352,898	542,500	714,966	1,400,000	1,750,000
Subtotal, Welfare Administration	371,911	563,263	743,089	1,443,278	1,793,500
St. Elizabeth's Hospital	44,500	30,500	25,500	31,000	36,000
Office of the Secretary:					
National Technical Institute for the Deaf			420,000	491,000	2,615,000
National advisory committee on education of the deaf				100,000	100,000
National conference on education of the deaf		100,000		100,000	
Model secondary school for the deaf					700,000
Subtotal, Office of the Secretary		100,000	420,000	691,000	3,415,000
Total, Department of Health, Education, and Welfare	24,301,252	27,779,609	38,619,298	49,279,356	58,042,468

PROGRAMS IN HEARING, SPEECH, AND LANGUAGE

Preface

The prevalence of communication disorders can be more readily understood in the facts and figures supplied by the United States National Health Survey of 1959–1961 which disclosed that 8,000,000 Americans have hearing, speech and language handicaps. Hearing disorders alone account for approximately one-fourth of all impairments involving over 6,000,000 persons. Profound or near-profound deafness prevents 250,000 persons from acquiring language, speech, and knowledge by ordinary means. Persons with handicapping speech problems number over 1,500,000. Their disability relates to cleft palate, aphasia, stuttering, laryngectomy, mental retardation, or cerebral palsy.

Strides in medicine, education, and rehabilitation are showing that much can be done to assist the communicatively handicapped indivadual to take his place as a productive member of society. Specific techniques vary with the nature and severity of the disability but almost all individuals can be helped to overcome, at least partly, their handicaps. Medical and surgical treatment, artificial aids, language and speech therapy, and other newly developed techniques are restoring the speech and hearing of many persons and sharply reducing the handicaps of others.

Increased financial support over the past several years has stimulated the Vocational Rehabilitation Administration, the Public Health Service, the Office of Education, and the Welfare Administration to mount more effective programs to meet the needs of persons with communication disorders. Among the especially noteworthy items of progress are the following:

The Vocational Rehabilitation Administration continues to expand its programs of training and research in speech pathology, audiology, and rehabilitation of deaf persons. Improvement of vocational training for deaf persons is receiving special emphasis. Recent legislation has authorized the establishment of a National Technical Institute for the Deaf and use of existing community facilities for the vocational training of deaf persons. Postmaster's and post-doctoral graduate study and short-term training courses related to rehabilitation of the adult aphasic and the larngectomee are in progress. A study has revealed that 900 of approximately 1,000 former trainees in the fields of speech pathology and audiology are employed in rehabilitation settings which provide services to adults with communicative disorders.

The Office of Education has further expanded its activities related to improving and enlarging educational opportunities for hearing, speech, and language handicapped children. Training grants awarded to colleges and universities are steadily increasing the number of professionals trained to work with communication disabled children and research and demonstration projects are determining the effectiveness of special education methods.

Captioned Films for the Deaf are expanding services to deaf persons through multiple distribution facilities and the improvement of techniques for cap-

tioning films. Also during Fiscal Year 1966, through P.L. 85–905, there has been expansion of visual aid services for deaf persons.

The Children's Bureau continues to encourage, through its grants program, demonstration research projects and training programs, the development and improvement of programs in State health departments and crippled children's agencies for children with communication disorders. A major conference was held to assess the scope and direction of future training needs in speech pathology and audiology.

The Public Health Service neurological and sensory disease service program continues its activities in expanding community service programs for persons with communication disorders. It also provides support to graduate training programs in speech pathology and audiology for persons who plan to provide services in medical environments.

The National Institute of Neurological Diseases and Blindness has developed a comprehensive program to promote understanding of the fundamental nature of human communication and its disorders. The Advisory Council Subcommittee on Human Communication and its Disorders provides guidance for these activities and organizes special conferences.

St. Elizabeth's Hospital has been operating a speech and hearing clinic for four years. The clinic is equipped to offer a wide variety of evaluative and rehabilitative procedures and affords excellent opportunity for development of research and clinical training activities.

The Office of the Secretary has administered programs which have included the following activities: the appointment of a National Advisory Committee on Education of the Deaf; the appointment of a National Advisory Board for the National Technical Institute for the Deaf; and plans to conduct a national conference on education of the deaf.

VOCATIONAL REHABILITATION ADMINISTRATION

Summary of programs for the deaf, for the hard of hearing, and for the speech impaired

The limited achievement in vocational rehabilitation of persons with communication disorders makes the promise and challenge of Vocational Rehabilitation Act Amendments of 1965 (Public Law 89–333) especially significant. The complexity and diffusion of the problems that surround hearing deficiencies and speech impairments require bold new concepts of service for their effective solution. Focus on the adjustment needs of deaf persons previously classified as not feasible for vocational rehabilitation can be expected to lead to development of appropriate services and training opportunities. Likewise, improved programs and services for the hard of hearing and the speech impaired will bring greater occupational fulfillment and a more satisfactory living pattern.

Americans who are vocationally handicapped by varying degrees and kinds of communication disorders exceed 8,000,000 in number. Some have disorders of the ears, the normal channels for *receiving* verbal messages. Some have defects in the vocal mechanisms, the main means for *sending* verbal messages. Some have disorders of the central nervous system which interfere with receiving and sending even though the ears and vocal apparatus are whole. Some have peripheral involvements that curb free verbalization. Some have combinations of causes.

The complexity and variety of the causes frequently obscure the fact that speech and hearing are variables that fluctuate with physical, mental and emotional conditions. Normal ears, normal mentality, normal vocal mechanisms, and so on should result in normal hearing and normal speech. One abnormality or more results in abnormal communication. The person permanently affected faces formidable barriers. Fortunately, the condition for many is transitory due to the wonders of medicine and related disciplines. These are not among the above named 8,000,000 whose disabilities are constant, who continuously search for ways to reduce the handicap of communication limitation.

Vocational rehabilitation workers share with teachers, audiologists, speech pathologists, medical workers, and others the responsibility to create, extend and improve knowledge and resources by which the communicatively handicapped can attain adjustments commensurate with their mental and residual physical capacities.

The deaf

Deafness is, in fact, a multiple handicap. Total lack of hearing prevents the individual from using a major way of communicating with others. It also denies him the personal enjoyment that others receive through listening. More importantly, however, he cannot utilize his hearing as an ever-alert warning system of approaching danger which cannot be detected through the eyes. For those who are born deaf, their handicap imposes a most serious deficit upon their ability to learn language, which is fundamental for future intellectual and educational development. Finally, and perhaps most penalizing of all, deafness is a hidden disability. The deaf person moves and lives in a hearing world, unidentified but isolated.

VRA has long given special priority to research and demonstration projects which attempted to define and resolve the many problems of the deaf. The task, however, is overwhelming in its magnitude. Many questions remain to be answered, and for every answer found, new questions emerge. For instance, how best can the deaf be helped to secure and keep jobs in spite of the fact that their traditional entry jobs in industry are rapidly being eliminated by automation. The deaf, themselves, ask whether they can ever realistically hope for job advancement and promotion or whether they must confine their goals to low level jobs and menial tasks, as at present. On the social front, research is showing many unmet needs for the deaf. At present, the deaf do not have access to the kinds of medical guidance and advice that are so readily available to all other segments of our society; few physicians know how to communicate through finger spelling and the language of signs and written messages are a poor foundation for an adequate diagnosis. This language barrier is particularly evident in the area of mental health counseling for the deaf. Many deaf individuals who need and could benefit from such guidance may develop serious and incapacitating problems if it remains unavailable. The question of how psychotherapy can be carried on between a psychiatrist and a deaf person through manual communication is just now beginning to be answered through pioneering research sponsored by VRA. Basic to all these problems are the unanswered questions about the language development and functioning of the deaf and the yet undiscovered ways that creative and flexible language skills can be taught to them effectively and efficiently.

Research and demonstration activities have already resulted in a better understanding of the problems which exist. They also have shown the way for a better solution for many of the problems. The major task of finding answers and implementing them remains to be done.

The 250,000 deaf people have very complex problems. Many of them are without useful speech despite years of training. Many have limited language skills. They receive messages principally through their eyes. They send messages by combinations of signs, gestures, speech, and writing. Most of them have normal strength, mobility and intelligence. They strive for achievement within the limitation society imposes in the fact of their inadequate verbal communication. This is the handicapping base of their disability. It is primarly psycho-social. It manifests itself in many ways: Underinvolvement in the main stream of community life; limited sharing with fellowmen; lack of acceptance among neighbors, employers, and fellow employees; severe underemployment. It seldom yields at all to medical intervention such as drugs, surgery or prosthesis. It does yield in approximate ratio to their availability in quality and depth, to training and adjustment services that stem from comprehensive, expert diagnosis that may involve disciplines of psychology, audiology, medicine, and education and to public relations activities that stress the deaf person's strengths.

Two deep-seated problem areas for vocational rehabilitation exist with respect to deaf people. First, the most basic and achievable need of the deaf person, specifically skill in reading and writing, is insufficiently emphasized in childhood training. Formal training has generally so heavily emphasized the development of speech skills in the deaf child that speech has erroneously assumed the position of being the equivalent of rather than a vehicle for language. To put it another way, teachers of the deaf have focused disproportionate time and energy upon an outlet (speech) for language rather than power in language itself. Language and speech are referred to interchangeably, confusing professional and lay workers alike. Hence, the handicapping aspects of deafness are often intensified by a needless wall of language deficiency.

Second, an incorrect image of the deaf person's potential in verbal communication skills stems from this heavy emphasis on speech and frequently unrealistic publicity that generates from it. These together create everywhere an expectancy in oral communication performance which very few deaf people can fulfill. Employers and others are, thus, not conditioned to look beyond the poor speech for the hidden, often rich, human resources.

The Vocational Rehabilitation Administration is attacking the roots of underemployment: (1) By encouraging and assisting in the establishment of rehabilitation centers to diagnose and train deaf people; (2) by extending its training operations (a) to reduce the communication barrier facing deaf people by developing standards and new procedures for speech conservation and instruction in sign language, (b) to qualify more professional workers in psychology, social work, vocational rehabilitation, speech therapy and audiology to work with the deaf, (c) to develop better understanding of the potentials of deaf people among vocational rehabilitation workers and others, including employers and community leaders, (d) to improve the understanding among professional and voluntary workers of how they can assist the State vocational rehabilitation agencies in serving the deaf, and (e) to help deaf people and their co-workers develop more productive concepts of community inter-relationships; (3) by encouraging researchers to study and resolve the many economic, social, and psychological problems associated with deafness.

The hard of hearing

The several million hard of hearing pose quite different problems from the deaf. The two groups cannot be treated as one. Whereas the deaf receive verbal communication almost solely through their eyes, the hard of hearing rely principally upon their ears, even though these are defective. The hard of hearing generally have near-normal speech and language. Their disability often had a late onset as opposed to the early affliction of the deaf. Partial hearing impairment is less a psycho-social than a medical problem and often yields significantly and quickly to medical intervention and prosthesis with speedy return to old job or a new one.

It is known that the number of individuals with debilitating hearing loss is far greater than those who have lost their hearing completely. How much greater is unknown. More accurate estimates are needed before the full magnitude and vocational significance of this problem can be assessed. Deteriorating job performance, eventual loss of job, and gradual withdrawal from family and society are three of the more obvious results of gradual and progressive hearing loss. Too few of these people request help from the State divisions of vocational rehabilitation.

The problems of the hard of hearing are many; this the State vocational rehabilitation counselor knows. How best to solve them, no one yet knows. Much remains to be accomplished in helping the hard of hearing person retain the skills he had before the onset of his handicap. Better diagnostic methods need to be developed to permit earlier prediction or identification of hearing loss. Such methods would also enable a more successful prescription of hearing aids. Abilities which permit a person to speech read (lipread) successfully are, at present, unidentified. And yet, accurate prediction of such ability would have profound effects on the rehabilitation management of hard of hearing and deaf children as well as adults.

Further attention should also be given to ways of helping the person with progressive hearing loss retain his speech intelligibility while he is losing his major sensory pathway for judging the accuracy of his speech production.

The speech impaired

The speech impaired, including the language impaired, necessarily include many of the deaf and the hard of hearing because normal speech production depends to a great extent upon self-monitoring which in turn depends largely upon the speaker's hearing. We hear ourselves and correct as we go along. It is not the same for the hearing disabled. However, the speech impaired also number millions whose abnormal or absent output stems from organic disorders other than hearing.

The special needs of stroke victims, particularly those with debilitating language problems due to aphasia, have recently received nation-wide attention. Surprisingly little, however, is known about the actual incidence of the disability, particularly in its more subtle and partial forms. Also, diagnostic techniques to determine the most appropriate treatment problem and the outlook for recovery

remain crude and inexact. Unavailability of crucial specialized services within the aphasic's home community, particularly language therapy, poses insurmountable problems for most aphasics living outside large metropolitan areas. New methods of extending services to those people and/or training other family members to assume the task must receive highest priority. The use of programmed teaching machines represents one partial solution to this problem, but self-teaching programs must be developed and evaluated. The spotlight of attention given to this affliction merely highlights the problems which are as yet unsolved.

Equal attention has recently been given to cancer victims. In great need of rehabilitation are those who have lost their larynx because of cancer, thus, their ability to produce voice. Such a sudden handicap usually results in loss of job and loss of family responsibility. Training procedures now exist to help the laryngectomees learn to use esophageal speech, but too often, those methods fail. Many individuals, therefore, go for the rest of their lives without the ability to speak. Reasons for this failure must be found. Better techniques for identifying those people who will be able to learn esophageal speech—and those who will not—are needed. Programmed learning methods also need to be considered as possible retraining procedures. Presurgery personality factors deserve investigation as probable reasons for post-surgery response to rehabilitation efforts.

Stuttering is another wide-spread speech handicap which deserves greater research attention. Over 1,000,000 people in the United States suffer from this affliction. The problems of the adult stutterer are particularly damaging and cause the individual to lead a restricted and sterile life. This is true primarily because the speech defect is variable; the stutterer rarely knows when he begins to speak whether he will talk normally or will produce a spasm of muscular tension and an explosion of distorted words. Most stutterers, therefore, remain constantly "on guard" and resort to bizarre tricks and body motions (which themselves attract attention) to avoid stuttering. Some stutterers even pose as deaf to avoid having to speak. Consequently, many stutterers of superior ability accept jobs which require little or no talking and remain at a level of employment far below their aspirations and capacities. Underemployment, self-imposed, may sometimes be the stutterer's greatest handicap.

Usually, these problems are most resistant to change, even though research has shown that most of the stutterer's speech problem has been learned and can be unlearned. The reasons for the tenacity of stuttering are unknown. What is particularly puzzling is the fact that for a few persons, long-time stuttering can be eliminated with relative ease. Clinical observation has indicated that there are different types of stutterers and much more research is needed to find ways of identifying each kind and the critical factors which determine their response to rehabilitation. Also, better ways of helping stutters achieve and retain more normal speech must be found. To do this, better methods of judging the effectiveness of speech therapy are needed. The goal is doubly worthwhile since if the stutterer's speech can be improved, most of the associated psychosocial and vocational problems which his stuttering creates will also be eliminated.

The State vocational rehabilitation agencies find that a major problem is the lack of guidelines that enable staff to relate speech impairment to occupational handicap. Moreover, standards of casework performance and progress in therapy are not so closely defined nor apparent in speech rehabilitation as in other areas. The resources that serve the hard of hearing can be effective for the speech handicapped if qualified staff are available. The Vocational Rehabilitation Administration drive for more hearing and speech centers relates to speech rehabilitation, too. Additionally, special emphasis is being given (1) to the development of authoritative literature on the handicapping aspects of speech disorders and their treatment and (2) to the fostering of voluntary work for the speech impaired throughout the national community on a level equal to that for the hearing impaired. Research in speech performance, production, and diagnosis continues.

Numbers served by State vocational rehabilitation agencies

The aim of the public vocational rehabilitation program is the preparation of the occupationally handicapped disabled person for suitable employment. The State vocational rehabilitation agencies actually determine eligibility and provide services using grant-in-aid funds administered by the Vocational Rehabilitation Administration.

All of the resources of the public vocational rehabilitation services are directed toward the occupational adjustment of the person whose disability is a vocational handicap. The media for attaining this end with each client are the case services that are patterned to individual needs. The research, training, and facility development activities of the Vocational Rehabilitation Administration and the State agencies are carried on for the purpose of strengthening case service techniques, developing new ones, improving the capacities of the case worker and the personnel upon whom he draws, and developing resources for better diagnostic, evaluation, training and restoration services. The dual aim of sharp increases in the quality and quantity of services and persons served permeates the whole program.

The extent to which the State agencies rehabilitated the deaf, the hard of hearing, and the speech impaired in the fiscal year 1964 through 1967 and the numbers estimated to be rehabilitated in fiscal 1968 are shown in the following table:

	Number of rehabilitants in fiscal year				
	1964	1965	1966	1967	1968
All rehabilitants	119,708	134,859	154,279	190,000	218,500
Number of rehabilitants with major disability of speech or hearing	8,798	9,720	10,640	13,500	15,300
Deaf	2,243	2,560	2,731	3,600	4,100
Hard of hearing	5,133	5,600	6,284	7,600	8,600
Speech	1,422	1,590	1,625	2,300	2,600

The total number of rehabilitants are actual for fiscal years 1964, 1965 and 1966; for fiscal years 1967 and 1968 they are estimated on the basis of State budget estimates and Federal funds requested. The number of rehabilitants in the various disability groups are actual for FY 1964, 1965, and 1966; for FY 1967 and 1968, they are estimated on the basis of the proportion in the group for the preceding 5-year period.

The effectiveness of casework rests in appreciable measure upon the joint planning of the counselor and the client. Clients who are hard of hearing or who have serious speech problems of other than hearing origin tax even the most skilled caseworker. Even so, counselor and client do have a line of verbal communication which encourages rapport. They can develop a good rehabilitation plan together. The profoundly deaf client, however, especially that large majority who have serious language deficiencies, are not able to communicate by normal means. This is the crux. There must be communication between counselor and client for effective casework.

The State agencies have recognized this basic factor and are moving to rectify it as qualified workers become available or through special training of current counselors. Thirty-five States[1] now have or are actively recruiting staff who may be classified as expert vocational rehabilitation workers for the deaf since they are trained as professional counselors and are also able to communicate by sign language with deaf clients. Several of the States are searching for additional qualified counselors because their caseloads of deaf clients have rapidly grown beyond the capacities of the special staff as their deaf citizens have become aware that the vocational rehabilitation agency was now able to work more effectively with them. The Vocational Rehabilitation Administration urges that each State should have at least one highly skilled vocational rehabilitation counselor for the deaf and preferably that there be one in each metropolitan area.

Service centers

Most of the many hearing and speech centers that have been established in the past twenty years have come into being in universities as training and re-

[1] Alabama, Arizona, Arkansas, California, Connecticut, District of Columbia, Florida, Georgia, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Michigan, Minnesota, Mississippi, Missouri, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Puerto Rico, Tennessee, Texas, Utah, Virginia, Washington, West Virginia, and Wisconsin.

search facilities, in large hospitals as service units, and in metropolitan areas. They fill vital rehabilitation needs in diagnosis, in evaluation, in training in lipreading, speech, and listening, and in fitting of hearing aids. We may have as many as 400 of widely varying levels of effectiveness and uneven distribution. Many thousands of people with communication problems are just too far away from even the least of these service centers and even further from the more technical assistance that they may need. For example, a hard of hearing person who is 50 miles away from lipreading instruction, auditory training, hearing aid evaluation, is not likely to be able to travel this distance several times per week for instruction and service. The Vocational Rehabilitation Administration is attacking this problem directly through a carefully designed project to bring the basic hearing and speech services that the majority of these disabled people need into the local community at a cost that it can afford to maintain, leaving for the more comprehensive center the intricate services needed by more difficult hearing or speech cases. Successful initial experiences with two projects now underway [2] will provide a prototype for a nationwide program that could bring basic hearing and speech rehabilitation services within reach of all.

The State vocational rehabilitation agencies are making important contributions to the availability of hearing and speech evaluation services through grants to extend and improve vocational rehabilitation services for the communicatively impaired.

The practical needs of deaf people are little related to speech and hearing centers. Almost all of them have had several years of intensive, expert training in speech and use of residual sound perception in their special schools. They need the same vocational rehabilitation services as other clients, specifically diagnosis, evaluation, training, counseling, and placement, but in *language* that they understand. There are very few persons in rehabilitation centers or vocational schools who can communicate with deaf people to the point where a good learning situation may be said to exist. Consequently, the Vocational Rehabilitation Administration has had to concentrate on developing centers where there are expert professional workers for the deaf. Usually, these have proven to the residential schools for the deaf. Diagnostic, evaluation, prevocational, and adjustment centers have been established or are planned at the State schools for the deaf in sixteen [3] States.

Encouraging by-products of this activity is the interest in other States and the growing efforts by established rehabilitation centers to qualify themselves to serve the deaf.[4] Community service centers for deaf people that are relieving residential schools for the deaf of counseling responsibility of deaf adults are located in three metropolitan areas.

Justification.—The most pervasive, persistent yet reducible problem of deaf people is their underemployment. It has always been so. The normal strength, mobility, and intelligence of deaf people do not help them find satisfactory employment, that is jobs that are appropriately challenging. Much manpower is wasted. Underemployment is increasing as job demands become more complex and preparation therefore less available.

The experience of the Vocational Rehabilitation Administration emphasizes that a principal cause of underemployment is inadequate training. Appropriate resources for deaf people of employable age simply do not exist. By appropriate resources we mean training situations which fully compensate for the handicapping aspects of the disability, that is by providing for the special communication needs of deaf people so that transfer of ideas, exchange of thinking really takes place at more than a superficial, fragmentary level.

It is widely recognized that formal training for most deaf people terminates at the elementary level or slightly above. The average age of departure of the mass of deaf students from this level of training is about 18 years. Moreover, recent reports suggest the average age of departure is dropping. This is disastrous, except for the small percentage who qualify for and go on to secondary and higher educational opportunities, because there is no permanent school or other fixed training situation which the young deaf person may consider and toward which he may aspire. There is an utter vacuum of opportunity aside

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[2] Macon, Ga., and Mansfield, Ohio.

[3] Alabama, Arizona, Arkansas, Colorado, Florida, Georgia, Indiana, Louisiana, Mississippi, Nebraska, New Mexico, Oklahoma, South Carolina, Tennessee, Vermont and Wisconsin.

[4] Seattle, Washington, Kansas City, Missouri and Pittsburgh, Pa.

from an occasional local situation, such as on-the-job training or a receptive vocational school for normally hearing people, which may rise and fall in accordance with attending circumstances. Moreover, apprenticeships are seldom available to deaf people for age or other reasons. None of these latter provides the rich depth in training experience by which a permanent institution with its highly skilled staff reaches and motivates the deaf person to be somebody.

The tragedy of these failures of our society to meet its responsibilities is that a large portion of deaf people can benefit very much from more training. However, when their formal schooling is terminated, there is no place for them to go for more at the time or when they are motivated to want more training.

Of continuing concern to the Vocational Rehabilitation Administration is the decline in the vocational training of deaf clients. The accelerating inroads of automation seem to have sharply reduced the number of entry level jobs by which the deaf have gained their footholds in industry. Consequently, more vocational training has been necessary for deaf people who frequently are being pushed aside by overcrowded vocational schools. This intensifies the training void for deaf people that exists between the special school system which generally terminates at 9th grade or less and Gallaudet College, a void which has nurtured and partially perpetuated their serious *underemployment*.

Accomplishments.—The establishment of the National Technical Institute for the Deaf authorized by Public Law 89–36 is a very important step toward reducing the underemployment of deaf people. It will contribute vital new concepts in the training of deaf people and through its special job development and placement program open employment that has not had many or even any deaf practitioners. The State vocational rehabilitation agencies will naturally be directly involved with every student.

The most promising accomplishments for that large fraction of deaf people who are the most severely handicapped because of limited or no formal education, emotional problems, mental deficiency, or other difficult-to-manage circumstances, have been the successful transfer to State operations of three pioneering Vocational Rehabilitation Administration conceived and sponsored research projects. These are glowing examples of research results being incorporated in regular operations.

The Michigan Rehabilitation Institute in Pine Lake is operating the personal adjustment and prevocational center for unemployed deaf men that the VRA supported in Lansing for over three years. It successfully demonstrated, through techniques that its staff developed, that uneducated, seriously maladjusted deaf men who have not been eligible for vocational rehabilitation because suitable services were not available could in fact be prepared for and placed in competitive employment. This center is a regional model from which equivalent service centers in other States will be established as soon as possible.

The VRA project at Lapeer (Michigan) State Home and Training School to demonstrate rehabilitation of the hospitalized deaf-retarded has been made a part of regular State operations. It is essentially a training operation to make retarded deaf individuals more effective, varying from greater individual contribution to in-institutional life to discharge to independent living of those who have been patients because of improper diagnosis. It is being developed as an innovation project for adoption in other States. It has unusual economic significance in view of the larger ratio of deaf persons in institutions for the mentally retarded.

The State of New York has absorbed after nine years of VRA supported demonstration the mental health project of the deaf in the New York State Psychiatric Institute. It is expected that other larger population States will emulate this pilot experience as mental health workers who are able to communicate with the deaf (the crux of the project) become available.

Training

Communication is the most complex aspect of human behavior. Impairments in the processes of communication—speech, language, and hearing—leave a multitude of problems in their wake. The child with a communication disorder may encounter overwhelming obstacles to learning and may find it difficult to establish the relationships with other children which are essential to growing up to healthy, stable adulthood. The adult who acquires a speech or hearing disorder may experience a variety of social problems. His livelihood may be endangered; he may withdraw from his friends and cease to be a participating

member of his community. It is not surprising, then, that persons with speech and hearing disorders form one of the largest disability groups in the country. What is surprising—and intolerable—is the fact that adults with communication problems form one of the smallest groups of successful rehabilitants.

The purpose of training grants in speech pathology and audiology is to increase the number of speech and hearing specialists qualified to diagnose and treat adults with communicative disorders. Teaching grants are made to assist university training centers to expand their programs and modify their curricula to provide more extensive training for work with adults. Prior to the initiation of the VRA training grants program, the majority of the programs traditionally prepared students to work with children in the public school system. A significant number of graduate training programs have modified their curricula to include extensive training in the area of adult rehabilitation. Traineeship grants are made to training centers so that students may gain experience with adults and so that experienced clinicians may secure advanced training to prepare for university teaching positions.

Accomplishments.—Significant progress is being made in the effort to alleviate the shortages of qualified personnel to diagnose and treat individuals with communicative disorders but shortages continue to exist. Since VRA began to support graduate training in this field in 1958, the number of universities with teaching grants has grown from seven to 65 in fiscal year 1966, and the number of traineeships from 23 to 684 in fiscal year 1966. Approximately 1,000 VRA trainees have completed their graduate study in this field and of this number over 900 (90 percent) are employed in rehabilitation settings which provide services to adults with communicative disorders.

The number of speech pathologists and audiologists who have met the requirements for the certificate of clinical competence, as established by the profession, has increased in the past few years. They now total over 6,000 as compared with less than 1,000 in 1958. Improvements in the graduate curricula account in large measure for this increase. At the present time it is estimated that less than 500 trained persons are providing services in postlaryngectomy or esophageal speech to the laryngectomee. More persons are being trained in this area through short-term training programs.

A very conservative estimate of the number of trained persons providing language and speech training to the aphasic on a full-time basis would be 250. In addition there are a number of speech clinicians, some with limited training, providing minimal services. Some of these clinicans may provide services to one or two aphasic patients each year. It is important that every speech clinician receive specialized training in working both with the laryngectomee and the aphasic. These competencies are most important to every clinician, working in a large rehabilitation center, in small community hospitals, private practices, or in any of the work environments.

Needs.—Precise figures on the number of speech pathologists and audiologists now employed are lacking. The membership of the American Speech and Hearing Association is now over 13,000, and there are perhaps an additional 5,000 persons working in the field who are not members. It is estimated that about 20,000 clinicians are required to provide the necessary services to the approximately 8,000,000 persons in the United States who have defective speech or hearing serious enough to handicap them in their social relationship and vocational adjustment. Approximately 800 students are completing their studies at the master's or doctoral level each year. This number represents about half of those needed to reach the goal of 20,000 trained clinicians in practice and 1,500 graduates a year.

Of the approximately 6,000 clinicians who have received the certificate of clinical competence, only 900 have certification in audiology and about 150 have dual certification. The need for bringing new workers into the field is clear and the increase in college enrollments will result in larger graduate student bodies. At the same time, many of the clinicians now working lack competencies in dealing with specialized problems, such as work with the laryngectomized patient, the adult aphasic, or those with profound hearing loss. There is a need for the continued training of these individuals who are presently providing only limited or inferior services.

Every rehabilitation environment should have at least one speech clinician who possesse the spherical competencies in working with the aphasic. This would mean that some 400 to 500 speech clinicians with special competencies

in working with the aphasic should complete their training each year. In addition, training should be provided to the clinicians presently in practice.

Estimated manpower figures in speech pathology-audiology are—

	1967	1968	1970
Number enrolled in graduate education programs:			
Master's degree	1,440	1,500	1,880
Doctoral	160	170	200
Number receiving VRA traineeships	773	792	1,207
Number of graduates:			
Master's degree	1,130	1,200	1,425
Doctorate	150	155	175
Number needed for replacement and to fill new positions	2,500	2,750	4,000

New activity.—A major effort in the recruitment of students to work in this profession is underway at the present time. It is anticipated that by 1968, effects of this activity will begin to have an impact on the graduate enrollment, and by 1972 some of the manpower needs will be met. This can be accomplished only through the continued increase in support of the program.

The 1968 proposed program.—In 1968 funds amounting to $3,267,000 are requested for support of 61 teaching grants and 678 traineeships, the same level as 1967. Components of this request are: $1,006,000 to continue support of 61 continuing teaching grants; and $2,261,000 for 678 traineeships.

Rehabilitation of the deaf

Trained personnel to meet the needs of people who are deaf are in short supply. Special skills are required to work with this group of handicapped persons. It is important for the trained worker to have some understanding of the psychological, social, and communicative problems of these individuals. The skill of manual communication is most important to the worker serving a deaf person whose verbal communication ability is limited or completely lacking. Teaching grants are made to prepare speech pathologists, audiologists, social workers, rehabilitation counselors, psychologists, physicians, and others to work with this specialized group. Research in this area continues to expand, but the quick incorporation into the curricula in the respective professional fields of new knowledge gained through this research continues to be difficult. Traineeship support is important to help prepare a number of individuals to work with the deaf.

Accomplishments.—Until recent years, academic programs to prepare personnel for rehabilitation of deaf persons did not exist in the United States except those of preparation of teachers of deaf children. In fiscal year 1961, VRA began support of a specialized training program at the master's degree level which was designed to prepare a small number of persons now working with the deaf for leadership positions in rehabilitation of the deaf. The curriculum drew upon a number of disciplines and is composed of both classroom instruction and actual field experience in varied settings serving deaf persons. In 1963, three programs were developed to provide orientation of professional personnel to work with the deaf, through training courses of four to six weeks' duration. These courses were primarily geared to meet the needs of rehabilitation counselors, social workers, psychologists and other rehabilitation personnel. In 1964, an inter-disciplinary program was developed to provide greater breadth and depth in the understanding of the problems of deaf persons. The students in this program are individuals from the fields of speech pathology, audiology, social work, or rehabilitation counseling. All of these programs are comparatively new and their full effectiveness will not be realized until the students have returned to their work environments to try the new skills and knowledge gained. So little has been done in the past in the rehabilitation of deaf adults that it is premature to attempt an objective assessment of accomplishments.

Needs.—Relatively few professional workers are now equipped with enough knowledge about problems of deaf persons or with skill in communicating with totally deaf persons. State vocational rehabilitation agencies need more counselors with adequate preparation for serving deaf persons. Only thirty-five of the agencies have even one counselor with special competence in serving deaf persons. Only eight State agencies have more than one such specialized counselor.

Although some university training programs in rehabilitation counseling offer limited field work experience in rehabilitation of the deaf, most of them are faced with inability to locate satisfactory facilities for student clinical practice. Counselors with knowledge of the problems of the deaf are needed in residential schools for the deaf, in public employment services, in rehabilitation facilities, in vocational schools, and in mental hospitals and schools. Skilled audiologists are needed in the schools for the deaf to assist in determining the level of residual hearing and its possible contribution to independent living and employment.

Manpower figures are—

Manpower estimates	Fiscal year		
	1967	1968	1970
Number of students enrolled in specialized training programs related to the deaf	95	100	125
Number receiving VRA traineeships	92	95	100
Number of graduates	75	80	85
Number needed for replacements or expansion	175	200	250

In 1967 program plans included the development of guidelines for case service standards for vocational rehabilitation counselors serving deaf people; increased activation of the registry of interpreters for the deaf; assistance in the establishment of a professional organization of rehabilitation workers for the adult deaf; and a pilot effort to develop an intensive training program for interpreters of the deaf.

New activities.—In 1968 program plans include the development of guidelines for the integration of special education and vocational rehabilitation; an intensive effort to interest psychiatrists in serving deaf people; development of guidelines for professional non-medical and lay workers in extending mental health services to the deaf; design of better techniques of comunication for severely handicapped deaf people; orientation of religious workers for the deaf to vocational rehabilitation; and the preparation of guidelines and standards for teaching the language of signs.

The 1968 proposed program.—In 1968, $551,000 is requested for 8 teaching grants and 81 traineeships, same level as 1967. Components of the request are $243,000 for continuation of eight teaching grants; and $308,000 for 81 traineeships.

Research

Rehabilitation of Deaf Persons

Accomplishments.—Investigations are being continued and broadened on a national level to determine the actual occupational status of young deaf adults. Two intensive surveys have already been completed in the New England States and the Southwestern States, and the findings were combined with those from earlier VRA-sponsored studies of the vocational achievements of the deaf in representative urban and rural communities. The most significant finding to emerge from these investigations was documentation of the fact that the deaf, as a group, were not receiving vocational training of a type which would prepare them to compete for or retain jobs in the present day labor market. Much of their present training was for jobs which are rapidly being eliminated by automation. An immediate outgrowth of these survey findings was the preparation and passage of Public Law 89–36, "To Provide for the Establishment and Operation of a National Technical Institute for the Deaf." It is intended that the newly-created Technical Institute for the Deaf will begin to provide the kind of modern training, counseling, and ancillary services which the deaf must have if they are to achieve suitable employment in the coming years.

Another of the many discoveries to emerge from these research surveys was the fact that most deaf adults who are working are grossly underemployed in view of their inherent intellectual and personal capacities. As a consequence of this finding, VRA-sponsored projects are now under way in St. Louis, Boston, Chicago and Little Rock to demonstrate the long-term value to society of providing continuing vocational counseling and training to the underemployed deaf adult as well as to the unemployed deaf persons. The projects are also investi-

gating the economic and educational feasibility of providing such services for the deaf in existing rehabilitation facilities, under the guidance of specially-trained personnel, rather than in more expensive and virtually non-existent vocational training centers established exclusively for the deaf. If these demonstrations prove productive, they will have widespread influences on future State vocational rehabilitation programs for the deaf.

Many projects are under way to demonstrate ways in which the hearing community can assist the deaf to become active and well-informed members. Two sociologists from Catholic University are completing their second study of the personal and social interaction of deaf and hearing people within a community in an attempt to discover unmet needs and unrecognized deterrents to effective relationships.

The close involvement of the vocational rehabilitation program with deaf people and the foregoing and other sociological studies have brought into focus the urgent need for a coordinating, referral, interpreting and suportive counseling service for deaf people in metropolitan areas. We have found that most deaf people seldom know about community services to which they are entitled and which they need. Moreover, the relatively few who do become clients of these services may remain very much underserved because of the severe communication problem inherent in their disability.

Consequently, their vocational rehabilitation potential may be seriously affected. We are now carrying out demonstrations of the kind of a supportive service communities can most economically provide while not duplicating other services. Speech and hearing societies in Pittsburgh, Kansas City, and Seattle are sponsoring community service centers for deaf people. A State-wide program is now operating in Utah under the State vocational rehabilitation agency. We expect to be able to support similar work in other hearing societies, in an independent voluntary agency, and a university.

The new authorization in Public Law 89-333 that permits Federal funds to be used for interpreting language in describing and providing services for deaf vocational rehabilitation clients without regard to economic need underscores the urgency of finding successful patterns for this needed community service.

DePaul University in Chicago is instituting a metropolitan mental health facility for the deaf patterned after the successful demonstration project recently completed at the New York State Psychiatric Institute which established new ways of providing professional psychiatric services through the use of the language of signs. In San Francisco, a pilot program will soon begin to demonstrate the mental health service needs of deaf people.

The need to explore untried employment areas for the vocational rehabilitation advancement of deaf people and better utilization of their talent and capabilities has focused interest on the theater. The O'Neill Foundation of New York City is presently conducting a pilot program in repertory theater for the deaf that holds considerable promise of opening an area of new employment opportunities for deaf people.

The newly established Research and Training Center at New York University holds great promise for the conduction of studies in breadth and depth that will yield answers to the persisting problems that continue to surround deafness.

The National Health Council and a distinguished committee of prominent citizens have joined with VRA in sponsoring the formulation of an American Council of Organizations of and for the Deaf. This Council will include representative members from approximately 20 national organizations concerned with the deaf and should provide an effective mechanism for consolidation of the many independent and largely ineffectual efforts made in behalf of the deaf at the present time.

We anticipate that this Council will take leadership in developing urgently needed services for the deaf community such as management of a nationwide program of communication improvement centers, the publication of a regular paper to keep deaf people aware of their opportunities and roles in the larger society, the development and management of an appropriate program whereby deaf people can share the cultural resources of society, a job development service, and so on.

Research scientists from other professional fields are also beginning to turn their interests and talents to the problem of the deaf. Medical geneticists and audiologists at Johns Hopkins University are conducting an exhaustive search for new classifications of hereditary deafness. Engineers at Northeastern University, Wayne State University and Gallaudet College are perfecting new teaching machines which should greatly improve methods of teaching intelligible

speech to the deaf. Joint research is being conducted by Ohio State University and the University of Zagreb, Yugoslavia, on a dramatically new technique for teaching the totally deaf to utilize sounds for possible understanding of speech. Further efforts along these lines relate to a project which is investigating the possible usefulness of technological developments coming from the space program as new sensory aids for the deaf. On another front, research projects at Vanderbilt University, Catholic University and the Institute for the Deaf in the Netherlands are investigating ways in which the characteristic lack of creative language in the deaf can be overcome.

The 1968 Proposed Program.—In 1968, a total of $966,000 is requested for 18 projects. Emphasis will be given to the establishment of demonstration centers to develop and test better methods of vocational evaluation and assessment of the deaf, techniques for their placement, specific counseling methods, and ways of establishing a closer association with business and industry during on-the-job trials. Efforts to expand the number of professional fields in which the superior deaf adult may find employment will also be made. Supporting these activities, research will continue into ways of improving the language and the psychosocial relationships of the deaf so they may function more effectively and competitively on the job. Continued search for new sensory aids for the deaf will be conducted.

Rehabilitation of Speech Impaired

Accomplishments.—Finding ways in which the stroke patient with aphasia can obtain more intensive language retraining is the purpose of a research project being conducted jointly by Ohio State University and the Catholic University of the Sacred Heart in Milan, Italy. Devices and materials are being developed and evaluated which provide the aphasic with opportunities for intensive drill and self-instruction in language during periods in which he is not receiving formal speech and language training from a qualified therapist. A new type of teaching machine, designed specifically with the aphasic's problems in mind, has been developed and is being tested in several clinical settings. This device, utilizing a typewriter keyboard, promises to increase ten-fold the amount of self-training opportunities presently available to the aphasic. An obvious extension of this research is determining the feasibility of the stroke patient using the programmed learning sequences and machines in his own home and with the assistance of his family. Should the investigators find that such home instruction is productive, one solution will have been found for the perplexing problem of providing specialized services to home-bound and rural stroke patients.

An initial research project has just been completed, with VRA support, a Washintgon University in St. Louis which may, eventually, pave the way for physical restoration of the laryngectomized patient who has lost his larynx because of cancer. Medical specialists have studied and identified some of the basic neurophysiological requirements necessary for the reestablishment of normal swallowing and voice production through reconstructive surgery.

Future research projects are being developed which will utilize this information with laryngectomized animals and, eventually, laryngectomized humans.

Several research programs are presently underway to determine better ways of helping adult stutterers obtain normal speech. Speech pathologists at Northeastern University are conducting careful studies of the therapeutic progress of stutterers, and concomitant psychological and physiological changes, in an attempt to determine factors associated with an improvement in speech and to predict the likelihood of a patient's successful rehabilitation. At Western Reserve University, work is underway to develop methods whereby reliable and precise judgments can be made of a stutterer's speech improvement. Ways of helping speech therapists ascertain the success of their own therapy with stutterers by establishing personalized but objective criteria of judgment are being tested at the University of Kansas Medical Center with the use of closed-circuit television and video tape. Also, scientists at the State University of Iowa are testing new methods for conducting therapeutic counseling for stutterers. Combined, the outcome of these 4 studies should represent a major advancement in the development of more precise rehabilitation techniques for this speech handicapped group.

At present, most of VRA-sponsored projects involving the hard of hearing concern the development of more precise audiologic measures to be used in diagnosis. Two projects, one at the Houston Speech and Hearing Center and the other at the

University of California Medical School, are independently investigating audiological findings which are proving to be predictive of the outcome of surgery for patients with particular types of hearing loss. These findings are of inestimable value to the surgeon in selecting potentially successful candidates for surgery and subsequent restoration of hearing. The University of Oklahoma Medical Center, The Johns Hopkins University and Vanderbilt University are undertaking the development of new audiologic tests which promise to provide some of the kinds of specific information State rehabilitation counselors and others need to be of greatest help to their hard of hearing clients.

In quite a different view, VRA recently awarded a contract for the writing and production of a stage play which would help inform the general public of the importance and seriousness of partial hearing loss. Reaction to the play's first public performance before the American Hearing Society was enthusiastically positive. The play script has now been made available to community group across the nation.

The 1968 Proposed Program.—For 1968, $314,000 is requested for 13 projects. Primary emphasis will be given to the development and establishment of better rehabilitation methods for the aphasic patient and the laryngectomized person. Community demonstration projects, involving a multi-disciplinary approach, will be encouraged. The feasibility of establishing an organized and standardized reporting system to be used with large numbers of aphasic patients across the country will be studied for the purpose of collecting sufficiently large amounts of data to permit predictive studies. Research concerning better diagnostic and treatment methods for laryngectomized patients will receive high priority. In the area of stuttering, particular attention will be given to new ways of treatment. The possible usefulness of operant conditioning therapy and pharmaceutical treatment, among others, will be considered. Determination of the true vocation significance of partial hearing loss seems to be a most critical need at this time and efforts will be made to find such answers.

OFFICE OF EDUCATION

Programs in hearing, speech, and language

According to the most recent estimates of the American Speech and Hearing Association, speech and hearing disorders account for more than 8 million handicapped individuals. Of the number, approximately 3 million possess hearing difficulties severe enough to interfere with communication and the development of normal speech and language. 125,000 of these are considered totally deaf, and thereby incapable of receiving any speech through the auditory mechanism. The remaining 5 million represent children and adults with significant speech and language difficulties generally unrelated or in part related to hearing disorders. Among the types of speech and language problems found are those related to stuttering, aphasia, laryngectomy, cleft palate, cerebral palsy, or mental retardation.

The Office of Education activities related to improving and enlarging educational opportunities for handicapped children has expanded significantly during the past year. A number of training grants have been awarded to colleges and universities to help increase the number of professionals trained to work with children with communication disorders. Several grants have also been awarded to training institutions for the purpose of developing graduate programs in the area of speech pathology and audiology. Research and demonstration projects are being carried out in several areas, such as determining the effectiveness of instruction in the classroom and other learning situations for communicatively handicapped children and youth.

To encourage State departments of education to expand their services to the communicatively handicapped in the schools, a national major conference was held by OE in the fall of 1966 for State supervisors in speech and hearing. Problems in the development of school programs with and without Federal assistance were identified and discussed by participants. A study of the recipients of OE training grants in Speech and Hearing under P.L. 85-926, as amended, revealed that almost all trainees and fellows have indicated the vocational goal of providing speech and hearing services in the schools.

Captioned films for the deaf continues to serve many deaf persons through expansion of distribution facilities and the improvement of techniques for captioning films. Also during fiscal years 1965-1967, through Public Law 85-905, there has been continued expansion of visual aid services for deaf persons.

In fiscal years 1966 and 1967, P.L. 89–258, approved October 19, 1965, expanded the program to provide audio-visual equipment to programs for the deaf, and expanded the training facility to include media institutes and media centers.

Title III of the Elementary and Secondary Education Act (P.L. 89–10) provides nonmatching grants directly to local education agencies to stimulate and assist in (a) the provision of vitally needed educational services not available in sufficient quantity or quality, and (b) the development and establishment of exemplary educational programs to serve as models for regular school programs. This program gives special consideration to projects that are truly innovative as well as being of high quality and responsive to local needs. In fiscal year 1966, 15 projects were funded at a total of $1,086,341.

Educational improvement for the handicapped

Grants for the training of professional personnel in the education of the deaf.—The school-age population of deaf children has remained relatively constant in the past few years. It is estimated that there are approximately 35,000 deaf pupils in the United States. Due to a shortage of teachers and other obstacles, about 20 percent are not receiving the specialized help necessary from schools and classes appropriately equipped to serve these children. A recent survey has identified an annual need for 500 new teachers of the deaf plus 300 more to overcome existing shortage and annual attrition.

Public Law 87–276, approved September 22, 1961, authorized a grant program of $1.5 million for 2 years to accredited public and nonpublic institutions of higher learning for the training of teachers of the deaf. This program was extended for an additional year in fiscal year 1964. In the three-year tenure of the act, 1,374 scholarships have been awarded to train teachers of the deaf.

The program was expanded in academic year 1965–1966 to include, in addition to the training of teachers, the preparation of college instructors, supervisors, administrators, and research personnel as authorized by section 301 of Public Law 88–164. A total of $2,533,000 was utilized in support of the program.

The program was incorporated by Public Law 85–926, as amended, and Public Law 80–105, in fiscal year 1967. It is expected that approximately $2,752,000 will be utilized to further support these program activities in academic year 1966–67 and 1967–68.

Grants for training professional personnel in education of children with speech and hearing impairments.—In the Nation today there are approximately 2,374,000 school-age children with significant speech difficulties and approximately 848,000 with serious hearing disorders. Due mostly to a lack of qualified personnel, only about one-fourth of these children are receiving the special services needed for their social and educational growth. A major Federal effort (authorized by Public Law 85–926, as amended) is now underway to assist, in some measure, in providing additional educational personnel.

During the academic year 1965–66, approximately 1,214 individuals received training in these areas of the handicapped. In addition, 17 program development grants were awarded to initiate training for speech and hearing specialists in geographic areas of the country where such programs are needed, but do not exist.

Approximately $2,619,000 will be available for the academic year 1966–67 and 1967–68 to continue this effort. These funds will support about 1,397 traineeships and fellowships and 14 program development grants.

Captioned films for the deaf

Continuing its second year under a $2.8 million budget, Captioned Films in fiscal year 1967 reached a total audience of 1,552,630. There are 1,400 groups being served. Educational film showings accounted for 970,000 of this number. The recreational film library numbered 220 titles and approximately 2,640 prints. Educational films numbered 220 titles and some 16,500 prints.

Equipment acquired by the Office of Education and loaned to 125 of the most populous schools for the deaf included 1,000 filmstrip projectors, 1,500 overhead projectors, 2,500 projection screens and 2,500 projection tables. Other media distribution reaching virtually every class of deaf children included transparencies, slide sets, filmstrips, and auditory training recordings.

Special attention was given to the training of teachers. Three six-week media institutes at the Universities of Nebraska, Tennessee, and Massachusetts provided special training to 90 teachers of the deaf from more than half of the States. Forty special media workshops of two-three days duration were provided in as many schools and a four-day meeting of university personnel train-

ing teachers of the deaf was held for representatives of 15 Southern States. A national symposium for school administrators convened 60 school heads to study the implementation of new media utilization in schools for the deaf. A full day's program on educational media for the deaf was presented to more than 700 classroom teachers gathered for their biennial convention.

A training budget of $1 million will permit continuation of four existing regional media centers for the deaf and support the establishment of a fifth for the Far West. Research, confined almost entirely to continuation costs, will require $750,000 and distribution activities to cover expanding media acquisitions will require $250,000.

Although most of the program will be the logical development of activities already underway, two new projects are planned. This is a new type of communication for the deaf involving normal speech plus supplementary visual clues provided by the hand. A second project will involve utilization of some 15,000 commercially obsolete teletypewriters for use by the deaf. These are being contributed by private industry and with minor modification can be used by the deaf for telephone communication. Use of this equipment for possible emergency purposes on a national scale is being considered.

Title IV, Part A of the Library Services and Construction Act Amendments of 1966 (P.L. 89–511) provides for books, other library materials, and library services to be made available to students in residential schools for the handicapped, including those who are hard of hearing, deaf, or have speech impairments, when the schools are operated or substantially supported by the State, providing the State has submitted and had approved a State plan for establishing and improving State institutional library services. Funds in fiscal year 1967 have been appropriated for planning purposes only.

One of the most important services of public librarians to disadvantaged and handicapped persons is in the area of functional literacy. The Cleveland, Ohio Public Library has established three reading centers and equipped them with easily read adult materials, filmstrips, games, and related materials for use in the basic education classes with an enrollment of approximately 2,000 persons. The centers are operated by a special staff, including a reading specialist (sociologist) and reading guidance aides.

Under the programs of the Manpower Development and Training Act, where moderately handicapped individuals can benefit from training, and ultimately be placed in jobs, they have received training in regular institutional programs. In other instances, special programs have been set up to serve persons with these handicaps. For example, the MDT program in New Jersey offered a training program to a group of deaf men: at the Clark School for the Deaf in Massachusetts, teachers of the deaf received upgrading and refresher training: and in New Orleans, the St. Mary's Dominican College program provided secretarial training for girls whose speech habits deterred them from employment.

In fiscal year 1966, under Section 302 of Public Law 88–164 approximately $609,330 was used to support nine research and demonstration projects. The following are examples of this research:

Colorado State University will conduct a survey to estimate the prevalence of speech and hearing disorders in school children. It is estimated that a sample size of approximately 200,000 would be required for a reliable estimate of prevalence. A secondary purpose of the study will be to compare disorder categories with other appropriate variables.

At the State University of Iowa researchers will develop improved retraining procedures for the school-aged child who stutters. To accomplish this goal, it will be necessary to (1) study the extent to which it can be generalized that factors which affect the frequency and severity of stuttering in adults have a comparable effect on the frequency and severity of stuttering in children, and (2) evaluate similarities and differences in principles and procedures of stuttering therapy between children and adults by conducting experimental therapy with both age groups.

The Office of Education supported thirteen research projects in fiscal year 1966 amounting to $267,607 through the Cooperative Research program. The following are examples of this research:

A project at LeMoyne College, Memphis, Tennessee is describing the speech patterns of Negro high school students of Memphis, Tennessee, focusing on both the more privileged and the less privileged student. The speech of students from three large, all-Negro high schools will be taped during classroom sessions and informal discussions. Several students will be asked to respond to material ob-

tained from the "Linguistic Atlas of New England". A description of the sound system, morphology, and syntax will be made by analysis of the data collected. This description will be used for comparison with the grammatical structure of "Standard American English".

Another project at the University of California is studying the effect of subvocal speech on reading. The purpose of the subject is to investigate certain processes involved in the development of reading ability, with emphasis on certain physiological processes. The importance of the information received by the beginning reader as to his muscular activity and his hearing, and the relationship of vocalization and subvocalization to the difficulty of reading materials will be studied.

A longitudinal study through the fourth grade of language skills of children with varying speech sound articulation in kindergarten is being conducted at the University of Minnesota. The objectives of this study are to (1) identify factors related to articulation, spelling, and reading at third or fourth grade, (2) study relationships of a variety of language skills over a period of time, (3) describe the development of consonant articulation, and (4) carry on ancillary studies with samples selected on different language variables.

Under Title VII of the National Defense Education Act the Office of Education is supporting six projects in the area of hearing and speech amounting to $203,955. These projects are concerned with problems such as the testing and modification of overhead projection transparencies for special use with classes for the deaf, the use of visuals and programmed instruction for teaching beginning reading to deaf children, and further research on speeded speech as an educational medium.

PUBLIC HEALTH SERVICE

Hearing, language, and speech

Disorders of hearing and speech, and neurological disorders which hamper or prevent language development are major national problems. This is true not only because of the large number afflicted and the health problems involved but because of their associated educational and economic implications. Because these disorders are so interrelated, they are usually referred to as the communicative disorders. This general concept also includes problems of voice and reading disability.

National Center for Chronic Disease Control

The Neurological and Sensory Disease Control Program was established to work with official and voluntary health agencies, professional organizations, institutions of higher learning, and other nonprofit groups to prevent, control, and/or eradicate neurological and sensory impairments.

The ability to communicate is vital if a person is to develop himself and to contribute to his family and make his maximum contribution to society. Yet, communicative disorders are one of the most prevalent handicapping conditions in this country. Hearing impairment is the greatest single disabling condition. There are several reasons why this is so. Speech and hearing impairments, which originate in childhood and persist to maturity, such as stuttering, faulty articulation, and language deficits due to sensory and cultural deprivation, have always been prevalent. Congenital problems, such as cleft palate, ostosclerosis, and cerebral palsy also frequently affect the ability to receive and/or transmit speech. In addition to these causes of communicative disorders, however, the technological advances of our modern civilization have increased the number of communicatively impaired persons. Industrial noise trauma and cerebral damage resulting from automobile accidents cause hearing loss. More important, modern medicine, through its strides in saving the child who might otherwise not survive long after birth, and in prolonging life, has been responsible for increasing the number of people living who are communicatively impaired. Children are saved, but they often have damaged nervous systems and congenital defects of significance in their eventual learning of speech and language. People are living longer, but often their hearing degenerates.

There is an acute shortage of trained personnel to care for the needs of the communicatively impaired. Of utmost importance is the shortage of professionally trained speech pathologists and audiologists. Specialized programs in schools, hospitals, and clinics, in their efforts to provide service in the absence of fully qualified professional personnel, frequently employ sub-professionals with

minimal training and experience. Facilities in which fully trained professionals are available frequently have long waiting lists which must be reduced if we are to meet the extreme needs in this area. In addition the geographic distribution of adequate clinical programs to provide the needed services is such that many areas of the country are, in effect, completely devoid of service. It has been estimated by the American Speech and Hearing Association that 1,500 speech pathologists and audiologists must be trained annually to meet the need for expanding and newly developing programs in schools, hospitals, and clinics, and to compensate for attrition in the field.

Many persons now working in the field completed their training a number of years ago. All too frequently, they have not had the opportunity for the short-term training needed to become acquainted with new techniques and developments. In audiology alone, new techniques of measurement of hearing loss for otologic and neurologic diagnosis have been developed so rapidly that few who are not in academic training institutions can keep up with all the advances. It is only through increasing the number of individuals currently being trained in this field and providing for continuing education for those currently employed that the extreme shortage of services can be alleviated.

There is a need for short-term training for others besides speech pathologists and audiologists if the needs of the communicatively impaired are to be met. There is a shortage of medical personnel to aid in the rehabilitation of the communicatively handicapped. The practicing physician needs to be made more aware of speech and hearing problems. For instance, many school-age children have unidentified and untreated infections of the middle ear, a threat to health in general and hearing in particular. Also, new developments in audiology have vital import for neurologists in the diagnosis of certain conditions of the brain stem and cortex.

In the area of applied research, the Program is primarily interested in the development of new diagnostic and therapeutic techniques and the adoption of these techniques on a large-scale basis in services for the communicatively impaired. Longitudinal studies, many of them interdisciplinary in nature, are needed to study the effects of therapy on a given problem. Many remedial techniques, such as the various approaches utilized in educating the deaf, have been in use for several hundred years without any scientific study or validation of their effectiveness. One of the aims of the Branch is to stimulate such research and introduce the results on the working level as soon as possible.

Training

During 1967, the Neurological and Sensory Disease Control Program will continue to support eight programs for training speech pathologists and audiologists, involving commitments of $466,000. Approximately two new grants will be made at a cost of $123,000 for a total commitment of $589,000 for the training of speech pathologists and audiologists.

Short-term training projects, by which a measure of continuing education is provided, will continue to be supported. During fiscal year 1967, we anticipate supporting three or four programs at a cost of $24,000.

Individual traineeships awarded to persons pursuing professional preparation in speech pathology and audiology will amount to $300,000 for the support of approximately 70 persons.

Programs in hearing, speech, and language

During fiscal year 1967, project grants totalling $731,000 will be funded. In accordance with the changing goals within the Public Health Service, stress is being placed on projects having unique demonstration capabilities in a community setting. One such project is aimed at identifying and treating American Indian students at a residential school, children who have unique hearing, speech, and language disorders in an inter-cultural environment. Another grant, which proposes to establish the first diagnostic nursery and preschool for hearing impaired children in one of the nation's largest metropolitan areas, was recently approved.

Other research sponsored by the Program includes a study to determine the clinical applicability and validity of evoked cortical response audiometry, and another to test and evaluate new techniques for early identification of dysarthrics. Preliminary investigations are underway to test the applicability of new instrumentation for pitch measurement, which is felt to be of diagnostic significance for detection of early carcinoma of the larynx.

Future program areas

Prevention of loss of hearing and speech and language deficits will continue to be of primary concern to the Program. The Program is further concerned that individuals already having such impairment have the most appropriate and suitable medical, educational, and rehabilitative services.

The Program is also concerned about involving itself in two new areas. The problem of effective hearing aid utilization is becoming increasingly acute due to such things as increased hearing loss due to advancing years and increased noise risk. The Program will concentrate on determining factors essential to effective hearing aid utilization and an increased awareness on the part of the professional and lay public of the need for an effectiveness with which hearing aids might be better utilized. Another area of Program concern is that of noise-induced hearing loss. In cooperation with other programs of the Public Health Service, the Program will attempt to synthesize and disseminate the most recent findings pertinent to hearing loss resulting from environmental conditions and will collate and disseminate recommendations for the effective control of such debilitating conditions.

Even more than in the past, increased activity in operational research is both fundamental and necessary as a foundation for the entire Program. Increased patient care cannot be achieved without the development, validation, and utilization of the newest and most effective clinical tools. The demonstration of how best such tools might be utilized is also of primary concern, for no matter how rapidly professional personnel are trained, the likelihood is that the growth of the problem will be greater than the persons trained to cope with the problem.

National Institute of Neurological Diseases and Blindness

The problem

Infants.—The evidence from the Institute's Perinatal Research Project indicates that by one year of age, 12 to 15 percent of children are neurologically deviant to some degree. For various reasons, 10 percent of the Project's live births are premature; of those weighing under 1,500 grams, more than 50 percent will have profound problems, including those of hearing, language, and speech, alone or in combination.

Children.—Among children, it is estimated that 12 out of every 10,000 in the population are totally deaf and that between 150 and 300 of every 10,000 suffer from severe hearing impairment. About 500 per 10,000 have some type of disorder of speech which affects articulation while 20 per 10,000 suffer from cleft palate, facial malformation, or other organic disorders affecting speech. Cerebral palsy afflicts 13 out of each 10,000 of this population; half of these have some hearing, language, or speech problem. Fifty out of every 10,000 children suffer retardation in speech development not caused by deafness. Voice problems are estimated at more than 60 per 10,000. Stuttering (not necessarily to be considered a speech disorder), affects 60 in every 10,000. In short, this means that 10 percent of the Nation's children suffer from some form of communicative disorder.

Specific dyslexia is a diagnostic term applied to a type of reading disability. The entity involves reversal of symbols, auditory confusion, and writing problems—including mirror-writing. The problem is far more serious among males, with a ratio of 14 boys to every girl afflicted. This kind of impairment may involve as many as 3 percent of school-age children.

Adults.—In the adult population between 25 to 44 years, hearing impairment amounts to more than 400 per 10,000; severe speech disorders have not been reported in credible estimates (the validity of one estimate, 65 per 10,000 population, has been questioned).

In another group, age 55 to 65 years, hearing impairment affects more than 800 per 10,000, while speech disorders appear to remain at the 400 per 10,000 rate.

By age 75 and over, hearing, impairment amounts to more than 2,500 per 10,000. There are no adequate estimates of the prevalence among the older groups of speech and/or language disorders. However, it is well known that between 1,500 and 2,000 laryngectomies are performed each year for laryngeal cancer and that there are between 15,000 and 20,000 who have had this operation. Since the larynx is essential for normal speech, these persons are able to speak only through a complete retraining process.

Thus, despite the fact that firm counts for these various communicative disorders are not available, it is apparent that they constitute a major problem, and that a large proportion of the more serious of them are neurologically based.

Causal factors.—The causes of deafness are numerous and varied. Many are congenital in origin. Included among these are some of genetic origin and some due to prenatal injury by toxins or infection. Maternal German measles, for example, has been proven to be a particularly important cause of congenital hearing impairment.

Deafness may also have its origin in the early neonatal period. Jaundice of the newborn often due to blood type incompatability of the mother and child (erythroblastosis) is a cause of hearing impairment and language deficit. Asphyxiation at birth is another similar cause. Bacterial infection in the neonatal period is common, especially in prematures, who may suffer permanent impairment as a result.

Many kinds of postnatal damage may affect the auditory system: head trauma, viral infections, pyogenic and influenzal meningitis, encephalitis, upper respiratory infections and secondary pyogenic infections (these account for almost 80 percent of hearing impairment within school-age groups), drug toxicity, and, occasionally in childhood, commonly in adulthood, otosclerosis. Without doubt, presbycusis or hearing impairment in the aging processes, is caused by a combination of atrophy and exposure in a noisy world.

Relative to language and speech problems, the picture is less definite. Many kinds of neurological or psychological disturbances or developmental anomalies may interfere with learning and remembering language meanings and with fluent speech output. Gross intellectual deficiency or maxillo-facial developmental anomalies are obvious causes, as is cerebral palsy in its various forms. It is clear, as well, that psychosocial deprivation is a major cause of deviation in language comprehension and delay in speech development.

Hearing disorders, genetic factors, and general intelligence are all causes of trouble in learning language and in speaking.

Program direction

The Institute supports an extensive research and training program relating to disorders of communication. This program includes many individual basic and clinical research projects at various medical centers; basic research at the Institute's laboratories in Bethesda; five multidisciplinary human communication research centers; a special emphasis on communication in the Institute's Collaborative Perinatal Project; and a newly created scientific information center on human communication.

Council subcommittee.—To review the entire field and identify areas of need, an NINDB Council Subcommittee on Human Communication and Its Disorders was formed by action of the Institute's Council early in 1965. Specifically, it was asked to provide: (1) a definition of the field of human communication and its disorders with emphasis on "the communication sciences"; (2) a determination of the prevalence of various disorders; and (3) an outline of unresolved problems and unmet needs. Clearly, this is an extensive undertaking. It is estimated that it will require 3 years; and that it will probably terminate with a national conference early in 1968.

Institute Conference at Princeton.—Last year the NINDB Council brought together at Princeton some of the world's outstanding authorities and researchers on the problems of "Brain Mechanisms Underlying Speech and Language." This conference offered a resume of the present state of knowledge, and indicated specific areas of research opportunity.

Research centers.—Five multidisciplinary centers covering various aspects of human communication research are being supported by the Institute. An investigation of the fundamental processes of hearing is underway at Princeton University. A program at the Central Institute for the Deaf in St. Louis is focused on problems of auditory communication and its disorders. At the University of Chicago, a unit of research beds was opened earlier this year to hospitalize cases of poorly understood types of deafness and vertigo as well as patients with disorders of vision. The Kresge Hearing Research Institute at Ann Arbor, Michigan, has been concerned with the causes of deafness, and work of scientists at the University of Florida includes physics and physiology of voice production, the psychology of speech behavior in children, parent-child communication and first language acquisition, linguistics, and voice pathology.

In addition, the Institute's cerebrovascular center at Boston University is emphasizing research on aphasia.

Perinatal project.—The Institute's Collaborative Perinatal Project, involving the study of more than 60,000 pregnancies and their outcome, is beginning to pro-

vide a fund of information about prenatal and perinatal factors causing communicative disorders.

In addition to an infant screening test, a "High Risk Register for the Better Identification of Children with Problems of Communication" has been developed, which covers antenatal factors, complications of labor, neonatal difficulty, factors in early childhood, and psycho-social factors. This register can be put to excellent use for purposes of screening for case detection, particularly in communities where direct screening and adequate special clinical facilities do not exist.

A third important aspect of the studies is an examination of infants at 36 months of age to evaluate their developmental status in terms of hearing, language, and speech.

Consideration is now being given to the inclusion of a corresponding examination when the children reach age 8.

Scientific Information Center.—The rapid increase in research and in the volume of research publications in the area of human communication makes necessary an efficient means of reviewing, evaluating, and disseminating information of significance and use to the scientific community. This is being undertaken by a newly developed Institute-supported Information Center on Human Communication and Its Disorders at The Johns Hopkins University.

Research Direction

Attention focused on the very young.—Major research emphasis of the 1966 NINDB-supported program into hearing, language, and speech impairments has been focused on (1) the causes that have their origin in the perinatal period, infancy, and early childhood; and (2) special techniques for early diagnosis and treatment. Early recognition of any defect of the hearing or speech mechanism is crucial to the learning process and the social development of the future citizen. It is estimated that today 10 percent of the Nation's children suffer some form of communicative disorder.

Rubella tied to deafness and ear infection.—Maternal rubella infection (German measles) was found to cause a considerable number of babies to be born deaf. In addition, this year's studies showed that babies born of mothers who had rubella but were not born deaf were, however, particularly predisposed to secondary middle ear infection endangering them to hearing loss. Detailed records of the Collaborative Perinatal Project are providing data on the magnitude of the problems as well as material for extensive study into the way in which maternal rubella effects the hearing mechanism of the child.

In one of the institutions collaborating in the Perinatal Project, 1,353 women in the study were pregnant during the epidemic of 1964. Approximately 10 percent of these pregnancies involved prenatal rubella, confirmed by virological or serological tests. Of these, almost half of the babies were carriers of live virus after birth for varying periods of time.

Study of the infants born under these circumstances have provided new and improved information on the effects of maternal rubella on hearing. In cases where this association is known, prompt recognition and treatment of ear infection can often be accomplished soon enough to prevent much of the progressive hearing loss which has previously been occurring in these infants.

Revised concept of bone conduction.—Sound waves are conducted to the organ of hearing in two ways—one through the air to the eardrum and the other by passage through the bones of the skull.

A revised concept of bone conduction of sound waves to the inner ear, based on 5 years of experimental work, promises to enable physicians to interpret more clearly the variations in bone conduction measurements found in ear diseases. The main points of the theory involve the three kinds of waves elicited by sound and the three modes of bone conduction responses of the ear. These findings have been integrated with prior knowledge of bone conduction.

A Research Career Awardee of the Institute has noted that the response of the normal ear to sound integrates all three modes and the various modifying components according to their amplitude and phase relationships. He emphasized that when specific parts of the ear are missing or functionally eliminated the total bone conduction response is altered accordingly.

Temporal bone bank program.—Bequeathed inner ear structures from persons with a long medical history of hearing problems are being studied through the Temporal Bone Bank Program. Within this program, studies of the organs of hearing and balance, hidden deep within the temporal bone, inaccessible for study during life, provide an important means of uncovering essential facts on

hearing disorders in human beings. A detailed study of human temporal bones may well provide the key to correlating structural and pathological changes with functional disorders of the auditory and vestibular systems. There are now some 30 cooperating temporal bone banks and laboratories located in major cities across the country.

Recognition and classification of communicative disorders.—There are several points of particular importance in the detection and management of those with communicative disorders. First is the need to employ a common, systematic nomenclature in describing communicative impairments. Second is the need for identifying the affected children and adults as soon as possible. Third is the need for standard tests and measurements, with clearly expressed criteria for success and failure.

The Institute's program is contributing materially to all three of these basic needs. Workshops on nomenclature are being held with national coverage in order to cover the so-called "consumer groups," hospitals, rehabilitation centers, and welfare services.

A major development has emerged from the study of infants in the Institute's Perinatal Project. A simple "distraction test" of responses of babies to acoustic stimuli has been given to several thousand infants. Approximately 10 percent fail at both 4 and 12 months. Of these, 4 in 10 have treatable middle-ear impairment associated with recurrent upper respiratory infection; 3-to-4 in 10 have some aspect of neurological deficit or deviation; and 5-to-6 in 10 have some kind of mental deviation. This simple screening test may become a powerful public health tool in case detection.

A considerable variety of research grants in the Institute's general research program is devoted to the development of further tests and measurements. This is particularly pertinent to three important aspects: (1) the refinement of speech-hearing tests of intelligibility; (2) the development of "mixed-message" tests for the better definition of auditory disorders of central pathways; and (3) the use of averaging computers in the study of electrophysiological responses to sound, particularly with infants and young children; several projects are concerned with norms and validating procedures.

Drug evaluation.—This year, there has been an intensification of studies of the harmful and beneficial effects on hearing of a broad range of chemical substances. Sodium fluoride is showing favorable laboratory results in treating one type of otosclerosis, a major cause of deafness. Minute amounts of sodium fluoride, a chemical commonly used to guard against dental cavities, has been demonstrated not only to have the ability to increase the deposit of calcium in bones, but also to retard the overgrowth of spongy tissue. This is providing a new approach to the control of otosclerosis of the cochlea, where a mass of spongy tissue can cause deafness by filling the lower area of the inner ear. Small amounts of sodium fluoride appear to be able to cause the system to reabsorb the tissue and restore hearing. (Cochlear otosclerosis is not to be confused with the type of otosclerosis where the stapes—one of the three tiny bones of the middle ear—has become immobilized so that it cannot transmit sound. A highly successful technique for surgically freeing the stapes and restoring this type of hearing loss is already in use.)

Investigation into the way in which the mycins (especially streptomycin) and the members of the chloroquine family act on the hearing and balance mechanisms of the ear are providing important information to aid in keeping dosage levels within the safety zone. Further study into the effect on loss of equilibrium (vertigo) by viomycin, a drug holding a major position in treatment of respiratory tuberculosis, is providing guidelines to physicians.

Basic research.—Computer techniques, applied to the analysis of electro-physiological responses, have been helpful in studying the auditory system recently. These electrodermal and electroencephalic responses are obtained by recording minute electrical currents of the skin and from the skull. The computer techniques made it possible to compile basic data on such responses by sex, age, and race; and also the repeatability of responses of both normal and abnormal subjects. These data greatly extend the usefulness of these methods in the study of abnormalities of the auditory system and are essential to their development into methods which eventually can be used in clinical practice.

Understanding of disease processes in the inner ear was further advanced during the past year by studies which clarified the source of the blood supply to the end organ of hearing; described the variational anatomy of certain portions

of the inner ear; and increased the understanding of the fluid balance in the inner ear. Each of these basic studies have important implications for surgery of the inner ear.

Nerve deafness.—The effective handling of certain types of deafness, it is hoped, may eventually develop from a new method of directly stimulating the hearing nerve reported by NINDB grantees. In one study, the auditory nerve of a 60-year-old man suffering bilateral sensory-neural deafness was subjected to direct electrical stimulation over an extended period of time. Six microelectrodes were permanently implanted directly in the auditory nerve, each tiny electrode or combination producing a characteristic pitch. The patient found that he could recognize gross differences between speech sounds and also identify simple tunes when electrical stimuli were presented through the electrodes.

This investigation was designed primarily to evaluate two aspects of perception: (1) the resolution obtainable by discrete stimulation of several small populations of auditory nerve fibers; and (2) differences between precisely controlled electrical stimuli and the more indirect or induction coil-activated stimuli used by many investigators in the past. It has been highly important in clarifying many of the previously controversial problems. If studies in line with this approach are continued and certain difficulties can be resolved, then the development of an artificial end organ may well become an actuality.

Noise sensitivity linked to sex.—Studies into the association between noise and hearing loss in industry, a major occupational problem, have brought out some surprising findings this past year. It has been demonstrated that the protective difference in the ear muscles of women makes them better than men for certain jobs in industry. Women are able to work at higher noise levels than men without suffering permanent hearing loss and can also hear higher tones above such noises more easily than men.

New technique favored with deaf children.—The development of skill in written language remains an area of major concern for teachers of the deaf. Results of experiments in the short-term training of deaf children through visually-presented program materials give promise of solving this problem. On the basis of one study, it appears that training in short-term memory for small units of meaningful language, visually presented, assists the deaf child in establishing memory traces for language patterns. The results of this study have implications for application with other populations, for example, the neurological impaired and mentally retarded children.

Rh damage to hearing clarified.—Another hearing impairment is one of the more common disorders observed in children who have suffered from neonatal jaundice due to Rh blood incompatability. For years, studies attempting to describe the site of the lesion causing this hearing impairment have been contradicatory. This past year, however, a group of Institute-supported scientists have done much to clarify the subject. Their study results favor the view that the auditory impairment caused by Rh incompatability is usually cochlear. However, there is a strong prospect that central lesions also occur, either along the cochlear lesion or independently. This finding has important implications in respect to the type of defect occurring in the child, the behavior he will exhibit, and his specific needs for treatment.

Testing for aphasia simplified.—A short examination for aphasia developed this year is providing an important advancement in reliable diagnosis over the whole range of aphasic disabilities. An Institute-supported investigator has designed a diagnostic scale and a severity scale to be used in conjunction with a range of language behavior tests intended to uncover the extent of aphasia impairment in the patients. The Diagnostic Scale specifies the underlying physiological process, summarizes the critical information obtained from each test section, and presents an overall view of the pattern of impairment in each patient. The Severity Scale estimates the abilities remaining in each language area and the level at which performance breaks down. It indicates what can be expected of the patient at a given time as well as the functional limitations imposed by aphasia.

Future plans

Future plans within the Institute's intramural program call for a broad-based increased research effort into the problems of neuro-otology, including the establishment of a new Branch to specifically deal with this area. This new unit will permit a multidisciplinary research effort not easily available at the existing medical centers.

(Statement describing Children's Bureau program in speech and hearing, 1966)

	Expenditures				Estimated	
	1963	1964	1965	1966	1967	1968
Special project grants	$343,761	$352,898	$542,500	$714,966	$1,400,000	$1,750,000
Salaries and expenses	14,608	19,013	20,763	28,123	43,278	43,500

The increase in expenditures in the fiscal year 1967 is derived to a large extent from speech and hearing services which are part of the comprehensive child health project for preschool and school children in low income areas, and also from speech and hearing training programs in relation to university affiliated centers for mental retardation. In addition, expenditures are made by the States from formula grants for maternal and child health and crippled children's services for speech and hearing activities, but no estimate of the amounts expended is available.

Program

A child's speech, hearing and language performance is so closely associated with his mental and social development that this ability to communicate is used as one of the measurements of his potential for further development. These communication skills develop during infancy and the preschool years. Among the conditions which adversely affect this development are hearing impairment, cleft palate, cerebral palsy, mental retardation, emotional disturbance and deprivation of motivation and stimulation to learn. Unable to hear adequately or to use speech effectively, the child is delayed in intellectual, emotional and social development. The earlier he can be identified and the sooner he receives medical and other special attention, the more likely it is that he will achieve adequate communicative skills. There are more than 2 million children with hearing impairments and another 2½ million with speech impairments.

In partnership with the State and local agencies, the Children's Bureau has developed and improved programs for providing services for children with speech and hearing handicaps. The objectives of these programs are:

(1) To discover children with partial or total loss of hearing with speech and language impairments

In 1964, the latest year for which nationwide data is available 45 State Health Departments reported testing the hearing of 5,340,000 children and referred 114,000 to physicians for further evaluation and treatment. All of the State Health Departments or State crippled children's agencies provide some medical and audiological services, including surgical treatment, hearing aids, auditory training and speech training.

These statistics reflect, for the most part, an almost universal school testing program. The Children's Bureau through professional consultation, demonstrations and conferences has focused attention on the need for earlier identification. Several States have expanded their efforts in the area of preschool and infant hearing testing. In Utah, for example, the Department of Health, using funds available for maternal and child health, has established a Statewide demonstration project for case finding and remedial services for communicative disorders. The innovative part of this program is the plan to evaluate the prenatal and natal health history of selected infants, and to provide all newborns with medical examinations and hearing testing while they are still in the hospital.

The development of programs for the early discovery of hearing impairment requires that the diagnostic evaluation procedures be refined. Therefore, support was extended by the Children's Bureau to the University of California, Los Angeles, to study the efficacy of using audiometry combined with computerized electro-encephalography (REG–A). Additional research proposals in this area are being scrutinized by the Children's Bureau staff for their applicability to service programs.

Programs for early casefinding require not only special training but also additional personnel. The Children's Bureau training program in speech and

hearing was expanded to include two grants which are unique among the grants available from Federal agencies. These two grants, made to Baylor University and to the New York University, have as their purpose the post-professional training of audiologists to evaluate the very young multiple-handicapped child. Additional training grants, similar to these, are being developed. Children who have been handicapped by the rubella epidemic of 1964–65 are a particular concern of these projects.

Direct support for expanded speech and hearing casefinding is included in most of the projects for comprehensive health services for preschool and school children, authorized by the 1965 Amendments to the Social Security Act.

(2) *To increase the amount and improve the quality of services for diagnostic evaluations and remedial services for speech, hearing and language disorders*

State crippled children's agencies reported in 1964 giving services to 29,000 children with hearing impairments and to 21,000 children with cleft palate or cleft lip, most of whom received speech therapy.

States, using grants made available through Title V, parts 1 and 2 of the Social Security Act and the mental retardation amendments of 1963, extended their services by employing additional speech and hearing personnel and by purchasing speech and hearing services from qualified centers. All but nine States have employed their State health department or crippled children's agency, speech pathologists or audiologists who have the responsibility for developing services for children with communication disorders.

In addition to the States' expansion of services, the Children's Bureau supported special projects in the amount of about $200,000 to demonstrate the contributions of speech and hearing specialists in providing services for multiple-handicapped children. These grants were made to the John Tracy Clinic in California, the Iowa Crippled Children's Division, the Multiple Handicapped Clinics in Kansas City, Columbus, Ohio; Childrens Hospital, D.C.; Baylor University; and the Department of Health in Colorado, Tennessee, Alaska, Hawaii, and Utah.

Approximately $225,000 has been committed for fiscal year 1967 for the provision of speech and hearing services in the projects for comprehensive child health services in low-income areas. The speech and hearing services extended to these areas will not only improve casefinding but will improve existing diagnostic and remedial services.

In an attempt to improve services related to the purchase of hearing aids from audiology centers, research support was continued to the American Speech and Hearing Association. The research will lead to guidelines which will be of significance to the programs administered both by the Children's Bureau and the Vocational Rehabilitation Administration.

Special projects for rehabilitation of children with cleft palate have been continued in Illinois, Maryland, Massachusetts, Montana and Virginia. An important objective of these projects is the provision of remedial speech and hearing services.

(3) *To initiate and support the development of professional training programs for speech pathologists and audiologists*

Support has been continued for training at six medical schools: Johns Hopkins Medical School, Vanderbilt University Medical School, University of Iowa, University of Kansas, Stanford University and the University of Oklahoma. The pilot program for nonacademic training in clinical services supported at the Iowa Crippled Children's Division was continued. Approximately $460,000 was expended on this total training program in fiscal year 1966.

During FY 1966 workshops and conferences held in Nashville, Portland and Denver at a cost of approximately $18,000, focussed on discussions of deafness in childhood, pediatric aspects of communicative disorders and public health speech and hearing services.

Plans for the further development of the training program in fiscal year 1967 are estimated to cost an additional $300,000. Most of these projects will be part of the training in the university affiliated centers. As part of this expansion, training for speech pathology and audiology is planned at the University of Texas, University of Virginia, University of Washington, University of Southern California, University of Tennessee, University of Oregon, University of Colorado, University of Minnesota, University of Missouri, and Ohio State University.

SAINT ELIZABETHS HOSPITAL

Speech and hearing programs report

Late in fiscal year 1963 and early 1964, Saint Elizabeths equipped and placed in operation a Speech and Hearing Clinic, located in its new Physical Medicine and Rehabilitation Building. In previous years, the lack of staff and equipment limited the program to rudimentary examinations, such as the screening of residual hearing acuity, cursory speech evaluations, and interviewing patients to secure case history data which might contribute to the adequate care and treatment of patients with speech and hearing complaints. When more thorough hearing evaluations were required, it was necessary to use the already crowded facilities of Gallaudet College. The limitations of staff and equipment restricted rehabilitation services to a small percentage of those patients at Saint Elizabeths Hospital who had speech and hearing problems. The Speech and Hearing Clinic is equipped to offer a wide variety of evaluative procedures including pure-tone and speech audiometry, involuntary response audiometry, and hearing aid evaluations as well as more thorough speech and language evaluations. Also offered are numerous rehabilitative procedures including speech reading, auditory training to help the patient make optimum use of his residual hearing acuity, speech conservation and correction to prevent and treat the deterioration of speech which often accompanies hearing impairment, and speech rehabilitation for patients with speech defects unrelated to their hearing acuity. Although evaluation and rehabilitation are the primary and immediate objectives of the Speech and Hearing Clinic, the versatility of the equipment and the patient population afford excellent potentials for the development of a research and training program.

During the 1965–66 fiscal year, the diagnostic audiology program was most effectively expanded; more extensive hearing evaluations were completed and more patients were seen than was possible previously.

The Speech and Hearing Clinic is also completing a study of the speech of patients with speech blockages (stutterers, spostic dysphuics and semantic aphasics), using the Cloze procedure; this is being done in collaboration with the Hospital's Behavioral Studies Branch. Early results indicate that the technique is proving to be highly successful as a differential diagnostic tool and suggests that it may have some value as a prognostic indicator in these syndromes.

OFFICE OF THE SECRETARY

National Technical Institute for the Deaf

The National Technical Institute for the Deaf (NTID) Act of 1965 (Public Law 89–36) authorized the Secretary, after consultation with an Advisory Board, to enter into an agreement with one institution of higher education for the establishment and operation of a residential facility for post-secondary technical training and education for persons who are deaf.

A National Advisory Board was appointed by the Secretary in December 1965 to assist him in the development of guidelines and procedures for the selection of an institute of higher education to participate in this project.

On recommendation of the National Advisory Board, on December 20, 1966, the Secretary entered into an agreement with the Rochester Institute of Technology for the establishment, construction, and operation of the National Technical Institute for the Deaf.

National Advisory Committee on Education of the Deaf

Provisions for the establishment of a National Advisory Committee on Education of the Deaf was made in Section 5 of Public 89–258. The Committee advises the Secretary of Health, Education, and Welfare concerning the carrying out of existing and the formulating of new or modified programs with respect to education of the deaf. One hundred thousand dollars was appropriated during fiscal year 1967 for this purpose.

National Conference on Education of the Deaf

In 1965, the Secretary requested $100,000 for a national conference on education of the deaf as recommended in the February 1965 report to the Secretary by his National Adisory Committee on Education of the Deaf. The $100,000 was appropriated by the 89th Congress in P.L. 89–309 and the conference will be

held April 13–15, 1967, under the sponsorship of the Secretary's National Advisory Committee on Education of the Deaf. The purpose of the meeting is to consider the problem of total state planning for the education and training of deaf children and youth. Dr. Paul A. Miller, Assistant Secretary for Education, will be Chairman.

Model Secondary School for the Deaf

Public Law 89–694 provides for the establishment of a Model Secondary School for the Deaf and authorizes the Secretary of Health, Education, and Welfare to enter into an agreement with Gallaudet College to operate such an institution to serve primarily residents of the District of Columbia and nearby States. The facility will provide day and residential facilities for secondary education for persons who are deaf in order to prepare them for college and other advanced study, and to provide an exemplary secondary school program to stimulate the development of similarly excellent programs throughout the country.

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