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GOVERNMENT

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DEVELOPMENTAL DISABILITIES SERVICES AND FACILITIES CONSTRUCTION ACT OF 1970

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HEARINGS

BEFORE THE

SUBCOMMITTEE ON PUBLIC HEALTH AND WELFARE

OF THE

COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE HOUSE OF REPRESENTATIVES

NINETY-FIRST CONGRESS

SECOND SESSION

ON

H.R. 15160, H.R. 14237, H.R. 15968, and S. 2846

BILLS TO AMEND THE MENTAL RETARDATION FACILITIES AND COMMUNITY MENTAL HEALTH CENTERS CONSTRUCTION ACT OF 1963 TO ASSIST THE STATES IN DEVELOPING A PLAN FOR THE PROVISION OF COMPREHENSIVE SERVICES TO PERSONS AFFECTED BY MENTAL RETARDATION AND OTHER DEVELOPMENTAL DISABILITIES ORIGINATING IN CHILDHOOD, TO ASSIST THE STATES IN THE PROVISION OF SUCH SERVICES IN ACCORDANCE WITH SUCH PLAN, TO ASSIST IN THE CONSTRUCTION OF FACILITIES TO PROVIDE THE SERVICES NEEDED TO CARRY OUT SUCH PLAN, AND FOR OTHER PURPOSES

(AND RELATED BILLS)

JUNE 9 AND 10, 1970

Serial No. 91-60

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ORGANIZATIONS REPRESENTED AT HEARINGS

- Association of Directors and Administrators of University Affiliated Centers:
 Chamberlin, Dr. Harrie R., director, University Developmental Evaluation
 Clinic, University of North Carolina.
 Gibson, Dr. William M., president.
- Health, Education, and Welfare Department:
 Black, Creed C., Assistant Secretary for Legislation.
 Jaslow, Dr. Robert I., Director, Division of Mental Retardation.
 Newman, Edward, Commissioner, Rehabilitation Services Administration.
- National Association for Retarded Children:
 Boggs, Mrs. Elizabeth M., Ph. D., chairman, Government Affairs Committee.
 Schmeidler, vice chairman, Government Affairs Committee.
- National Association of Coordinators of State Programs for the Mentally Retarded, Maurice G. Kott, Ph. D.
- National Association of State Mental Health Program Directors, Harry Schnibbe, executive director.
- New Jersey Division of Mental Retardation, Department of Institutions and Agencies, Maurice G. Kott, Ph. D., director.
- United Cerebral Palsy Associations, Inc.:
 Baird, John, national field representative.
 Helsel, Dr. Elsie, Washington representative.
- Virginia Association for Retarded Children, Karl Schmeidler, president.

DEPARTMENT OF COMMERCE
BUREAU OF COMMERCE
WASHINGTON, D. C.

TO THE SECRETARY OF COMMERCE

FROM THE
[Name of the person or organization]
[Address]
[City, State, and Zip]

The undersigned, [Name], of the [City, State], do hereby certify that [Name] is a [Nationality] and is [Age] years of age. [Name] is [Occupation] and is [Status] of [City, State]. [Name] is [Marital Status] and has [Number] children. [Name] is [Religion] and is [Political Party]. [Name] is [Education] and is [Profession]. [Name] is [Income] and is [Assets]. [Name] is [Debts] and is [Liabilities]. [Name] is [Other Information].

DEVELOPMENTAL DISABILITIES SERVICES AND FACILITIES CONSTRUCTION ACT OF 1970

TUESDAY, JUNE 9, 1970

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON PUBLIC HEALTH AND WELFARE,
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C.

The subcommittee met at 10 a.m., pursuant to notice, in room 2322, Rayburn House Office Building, Hon. John Jarman (chairman) presiding.

Mr. JARMAN. The subcommittee will please be in order.

The hearings today are on H.R. 15160, introduced by Chairman Staggers for himself and Mr. Springer at the request of the administration, H.R. 14237, introduced by myself, Mr. Rogers, Mr. Kyros, Mr. Preyer, Mr. Nelsen, Dr. Carter, Mr. Skubitz, and others, and all similar bills, to extend the program of matching grants for construction and staffing of facilities for the mentally retarded. Legislation having similar purposes, S. 2846, has also passed the Senate and will also be considered during these hearings.

In 1963, Congress enacted Public Law 86-164, authorizing matching grants for the construction of facilities for the mentally retarded. This program was expanded in subsequent years to provide grants for paying a declining portion of costs of professional and technical personnel at such facilities.

The bills under consideration today would in general revise the program to provide grants for construction and staffing of facilities for persons affected by developmental disabilities.

The purpose of these hearings will be to explore the extent to which the existing program needs to be further expanded and improved in order to provide more adequately for meeting the health needs of the American people in this area.

At this point there will be included the text of the bills and the agency reports thereon.

(The text of H.R. 15160, H.R. 16736, H.R. 14237, H.R. 15040, H.R. 15467, H.R. 15657, H.R. 16734, H.R. 15968, H.R. 16735, and S. 2846, and departmental reports thereon follows:)

[H.R. 15160, 91st Congress, 1st session, introduced by Mr. Staggers (for himself and Mr. Springer) on December 9, 1969, and H.R. 16736, 91st Congress, 2d session, introduced by Mr. Donohue on April 2, 1970, are identical as follows:]

A BILL

To amend the Mental Retardation Facilities Construction Act to extend and improve the provisions thereof, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*
3 That this Act may be cited as the "Mental Retardation
4 Services Amendments of 1969".

5 SEC. 2. Effective with respect to appropriations for fiscal
6 years beginning after June 30, 1970, title I of the Mental
7 Retardation Facilities and Community Mental Health Cen-
8 ters Construction Act of 1963 is amended to read as follows:

1 "TITLE I—GRANTS FOR SERVICES AND FOR CON-
2 STRUCTION AND OPERATION OF FACILITIES
3 FOR THE MENTALLY RETARDED

4 "SHORT TITLE

5 "SEC. 100. This title may be cited as the 'Mental Re-
6 tardation Services Act'.

7 "AUTHORIZATION OF APPROPRIATIONS

8 "SEC. 101. There are authorized to be appropriated for
9 grants under this title such sums as may be necessary for the
10 fiscal year ending June 30, 1971, and for each of the next
11 two fiscal years. For the fiscal year ending June 30, 1972,
12 and each of the ten succeeding fiscal years, there are author-
13 ized to be appropriated such sums as may be necessary to
14 make grants for projects which have received a grant under
15 this title from funds appropriated under the preceding sen-
16 tence, and are eligible for such a grant for the year for which
17 such sums are being appropriated under this sentence.

18 "AUTHORIZATION OF GRANTS

19 "SEC. 102. (a) Of the sums appropriated pursuant to
20 section 101 for a fiscal year, such amount as the Secretary
21 determines to be necessary shall be available for grants with
22 respect to facilities which received, prior to July 1, 1970,
23 grants under part D of this title as in effect prior to such
24 date, and which would have been eligible for such grants

1 in the same amounts under such part for such year had
2 such part remained in effect.

3 “(b) The remainder of the sums so appropriated for
4 such year shall be available for grants by the Secretary to
5 public or nonprofit private agencies and organizations for
6 up to 75 per centum of the cost (except as provided in sub-
7 sections (c) and (e)) of projects for—

8 “(1) provision of services for the mentally retarded,
9 including costs of operation, staffing, and maintenance
10 of facilities for the mentally retarded;

11 “(2) State or local planning, administration, or
12 technical assistance relating to services and facilities for
13 the mentally retarded;

14 “(3) training of physicians and other specialized
15 personnel needed for research, diagnosis, treatment, edu-
16 cation, rehabilitation, training, or care of the mentally
17 retarded;

18 “(4) developing or demonstrating new or improved
19 techniques for provision of diagnosis, treatment, educa-
20 tion, rehabilitation, training, care, or other services for
21 the mentally retarded; and

22 “(5) construction of facilities for the mentally re-
23 tarded, including facilities for any of the foregoing.

24 “(c) In the case of any project which is to be con-

1 structed, or to provide services for persons, in an area
2 designated by the Secretary as an urban or rural poverty
3 area, including planning and technical assistance in con-
4 nection therewith; the Federal portion of the cost thereof
5 which may be met by a grant under this title may not
6 exceed 90 per centum of such cost.

7 “(d) Payment of grants under this section may be
8 made in advance or by way of reimbursement, and in such
9 installments and on such conditions, as the Secretary may
10 determine.

11 “(e) No grant for any project to provide services to
12 the mentally retarded may be made under the provisions
13 of this title for a period in excess of eight years, or in
14 the case of any area designated by the Secretary as an
15 urban or rural poverty area, for any period in excess of
16 ten years. Grants with respect to the costs of any such
17 project may not exceed—

18 “(1) except as provided in clause (2), 75 per
19 centum of such costs for the first two years after the
20 first day of the first month for which such a grant is
21 made with respect to such project, 60 per centum of
22 such costs for the third year after such first day, 50
23 per centum of such costs for the fourth year after such
24 first day, 40 per centum of such costs for the fifth year
25 after such first day, 30 per centum of such costs for the

1 sixth year after such first day, 20 per centum of such
2 costs for the seventh year after such first day, and 10
3 per centum of such costs for the eighth year after such
4 first day; or

5 “(2) in the case of any such project providing
6 services for persons in an area designated by the Secre-
7 tary as an urban or rural poverty area, 90 per centum
8 of such costs for the first 2 years after the first day of the
9 first month for which such a grant is made with respect
10 to such project, 80 per centum of such costs for the third
11 year after such first day, 70 per centum of such costs for
12 the fourth year after such first day, 60 per centum of such
13 costs for the fifth year after such first day, 50 per centum
14 of such costs for the sixth year after such first day, 40 per
15 centum of such costs for the seventh year after such first
16 day, 30 per centum of such costs for the eighth year after
17 such first day, 20 per centum of such costs for the ninth
18 year after such first day, and 10 per centum of such costs
19 for the tenth year after such first day.

20 “TOTAL OF FEDERAL PAYMENTS IN A STATE

21 “SEC. 103. The total of grants under this title for all
22 projects in a State for any fiscal year beginning after June
23 30, 1970, shall not be less than the allotment to such State
24 for the fiscal year ending June 30, 1970, under section 132

1 as in effect prior to July 1, 1970, as computed prior to the
2 application of subsections (b), (c), and (d) thereof, except
3 to the extent that the Secretary determines that the total
4 cost of approvable applications for projects in such State for
5 such year will be less than such allotment.

6 "REGULATIONS

7 "SEC. 104. The Secretary shall prescribe general regu-
8 lations concerning the eligibility of projects, determination
9 of eligible costs with respect to which grants may be made,
10 general standards of construction and equipment for various
11 types of facilities of different classes and in different types of
12 location, and the terms and conditions for approving applica-
13 tions under this title.

14 "APPROVAL OF APPLICATIONS

15 "SEC. 105. The Secretary shall not approve any appli-
16 cation for a grant under this title unless he determines that—

17 "(1) the Governor (or, in the case of the Trust
18 Territory of the Pacific Islands, the High Commissioner)
19 of the State in which the project is to be located, or any
20 agency or official of the State designated by the Gover-
21 nor or Commissioner, has been afforded an opportunity to
22 review and make recommendations with respect to the
23 project;

24 "(2) in the case of an application for a project in a
25 State which has in existence a State mental retardation

1 construction plan, or comprehensive plan relating to
2 services for the mentally retarded, which has been re-
3 viewed by the State agency designated or established
4 pursuant to section 314 (a) (2) (A) of the Public Health
5 Service and by any other State agency determined by
6 the Governor to be appropriate, the project is consistent
7 with such plan or, if the State has both, with both such
8 plans;

9 “(3) there is reasonable assurance that the funds
10 paid with respect to the project under this title for any
11 period will be so used as to supplement and, to the ex-
12 tent practicable, to increase the level of State, local, and
13 other non-Federal funds for mental retardation services
14 which, in the absence of such Federal funds, would
15 otherwise be available for mental retardation projects in
16 such State and will in no event supplant such State,
17 local, or non-Federal funds; and

18 “(4) if the grant is for construction of a facility,
19 there is reasonable assurance that (A) for not less than
20 twenty years after completion of construction, the facility
21 will be used for the purposes for which it was con-
22 structed, (B) adequate financial support will be avail-
23 able for the construction of the facility and for its main-
24 tenance and operation when completed, and (C) all
25 laborers and mechanics employed by contractors or sub-

1 contractors in the performance of work on construction
2 of the facility will be paid wages at rates not less than
3 those determined by the Secretary of Labor in accord-
4 ance with the Davis-Bacon Act, as amended (40 U.S.C.
5 276a—276a-5) ; and the Secretary of Labor shall have
6 with respect to the labor standards specified in this
7 clause the authority and functions set forth in Reorga-
8 nization Plan Numbered 14 of 1950 (15 F.R. 3176,
9 5 U.S.C. 913) and section 2 of the Act of June 13,
10 1934, as amended (40 U.S.C. 276c).

11 "PROGRAM EVALUATION

12 "SEC. 106. Such portion of any appropriation under
13 this title for any fiscal year ending after June 30, 1970, as
14 the Secretary may determine, but not exceeding 1 per
15 centum thereof, shall be available to the Secretary for evalua-
16 tion (directly or by grants or contracts) of the program
17 authorized by this title.

18 "JOINT FUNDING

19 "SEC. 107. Pursuant to regulations prescribed by the
20 Secretary, where funds are advanced for a single project by
21 more than one Federal agency to an agency or organization
22 assisted under this title, any one Federal agency may be des-
23 ignated to act for all in administering the funds advanced. In
24 such cases, a single non-Federal share requirement may be
25 established according to the proportion of funds advanced by

1 each Federal agency, and any such agency may waive any
2 technical grant or contract requirement (as defined by such
3 regulations) which is inconsistent with the similar require-
4 ments of the administering agency or which the administer-
5 ing agency does not impose.

6 "NONDUPLICATION OF GRANTS

7 "SEC. 108. No grant may be made after January 1,
8 1964, under any provision of the Public Health Service Act,
9 for any of the fiscal years in the period beginning July 1,
10 1963, and ending June 30, 1973, for construction of any
11 facility for the mentally retarded described in this title,
12 unless the Secretary determines that funds are not available
13 under this title to make a grant for the construction of such
14 facility.

15 "RECOVERY

16 "SEC. 109. If any facility with respect to which funds
17 have been paid under this title shall, at any time within
18 twenty years after the completion of construction—

19 (1) be sold or transferred to any person, agency, or
20 organization which is not qualified to file an application
21 under this title, or

22 (2) cease to be a public or other nonprofit facility
23 of the type referred to in section 102 (b) (5), unless the
24 Secretary determines, in accordance with regulations,
25 that there is good cause for releasing the applicant or

1 other owner from the obligation to continue such facility
 2 as such a public or other nonprofit facility,
 3 the United States shall be entitled to recover from either the
 4 transferor or the transferee (or, in the case of a facility to
 5 which clause (2) applies, from the owner thereof) an amount
 6 bearing the same ratio to the then value (as determined by
 7 agreement of the parties or by action brought in the district
 8 court of the United States for the district in which the facility
 9 is situated) of so much of the facility as constituted an ap-
 10 proved project or projects, as the amount of the Federal
 11 participation bore to the cost of the construction of such
 12 project or projects."

13 AMENDMENTS TO GENERAL PROVISIONS

14 Trust Territory of the Pacific Islands Included in Definition
 15 of State

16 SEC. 3. (a) Effective with respect to grants under title I
 17 of the Mental Retardation Facilities and Community Mental
 18 Health Centers Construction Act of 1963 made from funds
 19 appropriated for fiscal years beginning after June 30, 1970,
 20 paragraph (a) of section 401 thereof (42 U.S.C. 2691)
 21 is amended by inserting "the Trust Territory of the Pacific
 22 Islands," after "the Virgin Islands,".

23 Facilities for the Mentally Retarded

24 (b) Effective with respect to projects approved under
 25 title I of such Act for fiscal years beginning after June 30,
 26 1970, paragraph (b) of section 401 is amended to read:

1 “(b) The term ‘facility for the mentally retarded’ means
2 a facility specially designed for the diagnosis, treatment,
3 education, training, or personal care of the mentally retarded,
4 including facilities for training specialists, group living ac-
5 commodations for the mentally retarded, and sheltered work-
6 shops for the mentally retarded, but only, in the case of such
7 sheltered workshops, if they are part of facilities which pro-
8 vide or will provide comprehensive services for the mentally
9 retarded.”

10 Cost of Land Included in Cost of Construction

11 (c) Effective with respect to projects approved under
12 title I of such Act for fiscal years beginning after June 30,
13 1970, so much of paragraph (e) of such section 401 as
14 follows the semicolon is amended to read “including archi-
15 tect’s fees and the cost of the acquisition of land, but ex-
16 cluding the cost of off-site improvements.”

17 State Standards for Variable Federal Share

18 (d) Effective with respect to projects approved under
19 title I of such Act for fiscal years beginning after June 30,
20 1970, section 402 of such Act (42 U.S.C. 2692) is amended
21 by striking out “part C of title I or”, and by striking out
22 “part or” in the first sentence thereof.

23 Payments for Construction

24 (e) Effective with respect to payments for construction
25 under title I of such Act from appropriations for fiscal years

1 beginning after June 30, 1970, subsection (a) of section
2 403 of such Act is amended by striking out "section 134
3 in the case of a facility for the mentally retarded, or", and
4 by striking out in clause (2) "section 136 or". Subsection
5 (b) of such section is amended by striking out "section
6 135 or".

7 Judicial Review

8 (f) (1) Section 404 of such Act is amended by striking
9 out "135 or", "134 (b) or", and "136 or" in the first
10 sentence thereof.

11 (2) The amendment made by paragraph (1) shall not
12 be effective with respect to applications submitted under
13 section 135 of such Act as in effect prior to the enactment
14 of this section, or appeals with respect to action under sec-
15 tion 134 (b) or 136 of such Act as in effect prior to such
16 enactment.

17 Recovery

18 (g) Effective with respect to construction projects for
19 which funds are paid out of appropriations for any fiscal
20 year beginning after June 30, 1970, paragraph (1) of
21 section 405 of such Act is amended by striking out "135 or"
22 in clause (A), and by striking out "section 134 (in the
23 case of a facility for the mentally retarded or" in clause (B)
24 thereof.

[H.R. 14237, 91st Congress, 1st session, introduced by Mr. Rogers of Florida (for himself, Mr. Jarman, Mr. Nelsen, Mr. Skubitz, Mr. Carter, Mr. Kyros, Mr. Preyer of North Carolina, Mr. Rhodes, Mr. Hastings, Mr. Van Deerlin, Mr. Blanton, Mr. Pickle, Mr. Murphy of New York, Mr. Dingell, Mr. Stuckey, Mr. Rooney of Pennsylvania, and Mr. Satterfield) on October 8, 1969;

H.R. 15040, 91st Congress, 1st session, introduced by Mrs. Dwyer on December 2, 1969;

H.R. 15467, 91st Congress, 2d session, introduced by Mr. Karth on January 20, 1970;¹

H.R. 15657, 91st Congress, 2d session, introduced by Mr. Galifianakis on February 2, 1970; and

H.R. 16734, 91st Congress, 2d session, introduced by Mr. Donohue on April 2, 1970 are identical as follows:]

¹ The short title on H.R. 15467 reads 1970 instead of 1969.

A BILL

To amend the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 to assist the States in developing a plan for the provision of comprehensive services to persons affected by mental retardation and other developmental disabilities originating in childhood, to assist the States in the provision of such services in accordance with such plan, to assist in the construction of facilities to provide the services needed to carry out such plan, and for other purposes.

- 1 *Be it enacted by the Senate and House of Representa-*
- 2 *tives of the United States of America in Congress assembled,*

1 SHORT TITLE

2 SECTION 1. This Act may be cited as the "Develop-
3 mental Disabilities Services and Facilities Construction Act
4 of 1969".

5 TITLE I—GRANTS FOR PLANNING, PROVISION OF
6 SERVICES, AND CONSTRUCTION OF FACILI-
7 TIES FOR PERSONS WITH DEVELOPMENTAL
8 DISABILITIES

9 SEC. 101. Part C of the Mental Retardation Facilities
10 Construction Act is amended to read as follows:

11 "PART C—GRANTS FOR PLANNING, PROVISION OF SERV-
12 ICES, AND CONSTRUCTION OF FACILITIES FOR PER-
13 SONS WITH DEVELOPMENTAL DISABILITIES

14 "DECLARATION OF PURPOSE

15 "SEC. 130. The purpose of this part is—

16 "(1) to make grants to assist the several States in
17 developing and implementing a comprehensive and
18 continuing plan for meeting the current and future needs
19 for services for persons affected by developmental dis-
20 abilities; and

21 "(2) to make grants to assist public and nonprofit
22 agencies in the construction of facilities for the provision
23 of services for persons affected by developmental dis-
24 abilities.

1 "AUTHORIZATION OF APPROPRIATIONS

2 "SEC. 131. (a) In order to make the grants to carry out
3 the provisions of section 130, there are authorized to be ap-
4 propriated \$60,000,000 for the fiscal year ending June 30,
5 1971, \$85,000,000 for the fiscal year ending June 30, 1972,
6 and \$105,000,000 for the fiscal year ending June 30, 1973.

7 "(b) For the fiscal year ending June 30, 1974, and
8 for each of the next six fiscal years, there are authorized to
9 be appropriated such sums as may be necessary to continue
10 to make grants under section 137 (a) (1) (B) with respect
11 to services for which a grant under that section was made
12 before July 1, 1973, and which are eligible for such a grant
13 for the year for which sums are being appropriated under
14 this subsection.

15 "STATE ALLOTMENTS

16 "SEC. 132. (a) (1) From the sums appropriated under
17 section 131 (a) for each fiscal year to carry out the purposes
18 of section 130, the several States shall be entitled to allot-
19 ments determined, in accordance with regulations, on the
20 basis of (A) the population, (B) the extent of need for
21 services and facilities for persons with developmental dis-
22 abilities, and (C) the financial need of the respective States;
23 except that the allotment of any State (other than the Virgin
24 Islands, American Samoa, Guam, and the Trust Territory

1 of the Pacific Islands) for any such fiscal year shall not be
2 less than \$100,000.

3 “(2) In determining, for purposes of paragraph (1),
4 the extent of need in any State for services and facilities
5 for persons with developmental disabilities, the Secretary
6 shall take into account the scope and extent of the services
7 specified, pursuant to section 134 (b) (4), in the State plan
8 of such State approved under this part.

9 “(3) Sums allotted to a State for a fiscal year and
10 designated by it for construction and remaining unobligated
11 at the end of such year shall remain available to such State
12 for such purpose for the next fiscal year (and for such year
13 only), in addition to the sums allotted to such State for
14 such next fiscal year; except that whenever the State plan of
15 a State calls for the construction of a specific facility the Fed-
16 eral share of which will exceed that State's maximum per-
17 missible allotment for construction for the fiscal year, the
18 Secretary may, on the request of the State, provide that funds
19 allotted to the State remain available, to the extent neces-
20 sary but not to exceed two additional years, to be combined
21 with subsequent allotments for the specified purpose.

22 “(b) Whenever the State plan developed in accordance
23 with section 134 provides for participation of more than one
24 State agency in administering or supervising the administra-
25 tion of designated portions of the State plan, the State may

1 apportion its allotment among such agencies in a manner
2 which, to the satisfaction of the Secretary, is reasonably re-
3 lated to the responsibilities assigned to such agencies in
4 carrying out the purposes of this part. Funds so apportioned
5 to State agencies may be combined with other State or
6 Federal funds authorized to be spent for other purposes,
7 provided the purposes of this part will receive proportionate
8 benefit from the combination.

9 “(c) The amount of an allotment to a State for a fiscal
10 year which the Secretary determines will not be required by
11 the State during the period for which it is available for the
12 purpose for which allotted shall be available for reallotment
13 by the Secretary from time to time, on such date or dates
14 as he may fix, to other States with respect to which such a
15 determination has not been made, in proportion to the
16 original allotments of such other States for such fiscal year,
17 but with such proportionate amount for any of such other
18 States being reduced to the extent it exceeds the sum the
19 Secretary estimates such State needs and will be able to use
20 during such period; and the total of such reductions shall be
21 similarly reallotted among the States whose proportionate
22 amounts were not so reduced. Any amount reallotted under
23 this subsection to a State for a fiscal year shall be deemed to
24 be a part of its allotment under subsection (a) for such fiscal
25 year.

1 "NATIONAL ADVISORY COUNCIL ON SERVICES AND FACILI-
2 TIES FOR THE DEVELOPMENTALLY DISABLED

3 "SEC. 133. (a) (1) There is hereby established a Na-
4 tional Advisory Council on Services and Facilities for the
5 Developmentally Disabled (hereafter in this part referred
6 to as the 'Council'), which shall consist of twelve members
7 to be appointed by the Secretary without regard to the pro-
8 visions of title 5, United States Code, governing appoint-
9 ments in the competitive civil service.

10 "(2) The Secretary shall from time to time designate
11 one of the members of the Council to serve as Chairman
12 thereof.

13 "(3) The members of the Council shall be selected from
14 persons who are not officers or employees of the United
15 States employed on a full-time basis and who are leaders
16 in the fields of service to the mentally retarded and
17 other developmentally disabled persons, in State or local
18 government, and in organizations representing consumers of
19 such services. At least four members shall be representative
20 of State or local agencies responsible for services to the de-
21 velopmentally disabled, and at least four shall be represent-
22 ative of the interests of consumers of such services.

23 "(b) Each member of the Council shall hold office for a
24 term of four years, except that any member appointed to fill
25 a vacancy occurring prior to the expiration of the term for

1 which his predecessor was appointed shall be appointed for
2 the remainder of such term, and except that, of the twelve
3 members first appointed, three shall hold office for a term of
4 three years, three shall hold office for a term of two years,
5 and three shall hold office for a term of one year, as desig-
6 nated by the Secretary at the time of appointment.

7 “(c) It shall be the duty and function of the Council to
8 (1) advise the Secretary with respect to any regulations
9 promulgated or proposed to be promulgated by him in the
10 implementation of this title, and (2) study and evaluate
11 programs authorized by this title with a view to determining
12 their effectiveness in carrying out the purposes for which
13 they were established.

14 “(d) The Council is authorized to engage such technical
15 assistance as may be required to carry out its functions, and
16 the Secretary shall, in addition, make available to the Council
17 such secretarial, clerical, and other assistance and such statis-
18 tical and other pertinent data prepared by or available to the
19 Department of Health, Education, and Welfare as the Coun-
20 cil may require to carry out such functions.

21 “(e) Members of the Council, while attending meetings
22 or conferences thereof or otherwise serving on the business
23 of the Council, shall be entitled to receive compensation
24 at rates fixed by the Secretary, but not exceeding \$100 per
25 day and, while so serving away from their homes or regular

1 places of business, they may be allowed travel expenses, in-
2 cluding per diem in lieu of subsistence, as authorized by sec-
3 tion 5703 of title 5, United States Code, for persons in the
4 Government service employed intermittently.

5 "STATE PLANS

6 "SEC. 134. (a) Any State desiring to take advantage
7 of this part must have a State plan submitted to and ap-
8 proved by the Secretary under this section.

9 "(b) In order to be approved by the Secretary under
10 this section, a State plan for the provision of services and
11 facilities for persons with developmental disabilities must—

12 "(1) designate (A) a State planning and advisory
13 council, to be responsible for submitting revisions of the
14 State plan and transmitting such reports as may be re-
15 quired by the Secretary; (B) the State agency or agen-
16 cies which may administer or supervise the administra-
17 tion of all or designated portions of the State plan; and
18 (C) a single State agency as the sole agency for ad-
19 ministering or supervising the administration of grants
20 for construction under the State plan;

21 "(2) set forth policies and procedures for the ex-
22 penditure of funds under the plan, which, in the judg-
23 ment of the Secretary, are designed to assure effective
24 continuing State planning, evaluation, and delivery of

1 services (both public and private) for persons with de-
2 velopmental disabilities;

3 “(3) contain or be supported by assurances satis-
4 factory to the Secretary that (A) the funds paid to the
5 State under this part will be used to make a significant
6 contribution toward strengthening services for persons
7 with developmental disabilities in the various political
8 subdivisions of the State in order to improve the quality,
9 scope, and extent of such services; (B) part of such funds
10 will be made available to other public or nonprofit pri-
11 vate agencies, institutions, and organizations; (C) such
12 funds will be used to supplement and, to the extent prac-
13 ticable, to increase the level of funds that would other-
14 wise be made available for the purposes for which the
15 Federal funds are provided and not to supplant such non-
16 Federal funds; and (D) there will be reasonable State
17 financial participation in the cost of administering and
18 implementing the State plan;

19 “(4) (A) provide for the furnishing of a range of
20 services and facilities for persons with developmental
21 disabilities associated with mental retardation, (B)
22 specify the other categories of developmental disabilities
23 which will be included in the State plan, and (C)
24 describe the quality, extent, and scope of such services as

1 will be provided to persons with mental retardation and
2 other developmental disabilities;

3 “(5) provide that services and facilities furnished
4 under the State plan for persons with developmental dis-
5 abilities will be in accordance with standards prescribed
6 by regulations, including standards as to the scope and
7 quality of such services and the maintenance and opera-
8 tion of such facilities;

9 “(6) provide such methods of administration (in-
10 cluding methods relating to the establishment and main-
11 tenance of personnel standards on a merit basis, except
12 that the Secretary shall exercise no authority with re-
13 spect to the selection, tenure of office, and compensation
14 of any individual employed in accordance with such
15 methods) as are found by the Secretary to be necessary
16 for the proper and efficient operation of the plan;

17 “(7) provide that (A) the State planning and ad-
18 visory council shall be adequately staffed and shall in-
19 clude representatives of each of the principal State
20 agencies and representatives of local agencies and non-
21 governmental organizations and groups concerned with
22 services for persons with developmental disabilities; and
23 (B) at least one-third of the membership of such council
24 shall consist of representatives of consumers of such
25 services;

1 “(8) provide that the State planning and advisory
2 council will from time to time, but not less often than
3 annually, review and evaluate its State plan approved
4 under this section and submit appropriate modifications
5 to the Secretary;

6 “(9) provide that the State agencies designated
7 in paragraph (1) will make such reports, in such form
8 and containing such information, as the Secretary may
9 from time to time reasonably require, and will keep such
10 records and afford such access thereto as the Secretary
11 finds necessary to assure the correctness and verification
12 of such reports;

13 “(10) provide that special financial and technical
14 assistance shall be given to areas of urban or rural pov-
15 erty in securing facilities and services for persons with
16 developmental disabilities who are residents of such
17 areas;

18 “(11) describe the methods to be used to assess
19 the effectiveness and accomplishments of the State in
20 meeting the needs of developmentally disabled persons
21 in the State;

22 “(12) provide for the development of a program of
23 construction of facilities for the provision of services for
24 persons with developmental disabilities which (A) is
25 based on a statewide inventory of existing facilities and

1 survey of need; and (B) meets the requirements pre-
2 scribed by the Secretary for furnishing needed services
3 to persons unable to pay therefor;

4 “(13) set forth the relative need, determined in
5 accordance with regulations prescribed by the Secretary,
6 for the several projects included in the construction pro-
7 gram referred to in paragraph (12), and assign priority
8 to the construction of projects, insofar as financial re-
9 sources available therefor and for maintenance and oper-
10 ation make possible, in the order of such relative need;

11 “(14) designate the portion of the State's allot-
12 ment (under section 132) for any year which is to be
13 devoted to construction of facilities, which portion shall
14 be not more than 50 per centum of the State's allotment
15 or such lesser per centum of the allotment as the Secre-
16 tary may from time to time prescribe;

17 “(15) provide for affording to every applicant for
18 a construction project an opportunity for hearing before
19 the State agency;

20 “(16) provide for such fiscal control and fund
21 accounting procedures as may be necessary to assure the
22 proper disbursement of and accounting for funds paid
23 to the State under this part; and

24 “(17) contain such additional information and as-

1 surances as the Secretary may find necessary to carry
2 out the provisions and purposes of this part.

3 “(c) The Secretary shall approve any State plan and
4 any modification thereof which complies with the provisions
5 of subsection (b). The Secretary shall not finally disapprove
6 a State plan except after reasonable notice and opportunity
7 for a hearing to the State.

8 “APPROVAL OF PROJECTS FOR CONSTRUCTION

9 “SEC. 135. (a) For each project for construction pur-
10 suant to a State plan approved under this part, there shall
11 be submitted to the Secretary, through the State agency
12 designated in accordance with section 134 (b) (1) (C), an
13 application by the State or a political subdivision thereof or
14 by any other public or nonprofit agency. If two or more
15 agencies join in the construction of the project, the applica-
16 tion may be filed by one or more of such agencies. Such appli-
17 cation shall set forth—

18 “(1) a description of the site for such project;

19 “(2) plans and specifications thereof, in accord-
20 ance with regulations prescribed by the Secretary;

21 “(3) reasonable assurance that title to such site
22 is or will be vested in one or more of the agencies filing
23 the application or in a public or other nonprofit agency
24 which is to operate the facility;

1 “(4) reasonable assurance that adequate financial
2 support will be available for the construction of the
3 project and for its maintenance and operation when
4 completed;

5 “(5) reasonable assurance that all laborers and
6 mechanics employed by contractors or subcontractors in
7 the performance of work on construction of the project
8 will be paid wages at rates not less than those prevail-
9 ing on similar construction in the locality as determined
10 by the Secretary of Labor in accordance with the Davis-
11 Bacon Act, as amended (40 U.S.C. 276a—276a-5) ;
12 and the Secretary of Labor shall have with respect to
13 the labor standards specified in this paragraph the au-
14 thority and functions set forth in Reorganization Plan
15 Numbered 14 of 1950 (15 F.R. 3176) and section 2 of
16 the Act of June 13, 1934, as amended (40 U.S.C.
17 276c) ; and

18 “(6) a certification by the State agency of the
19 Federal share for the project.

20 “(b) The Secretary shall approve such application if
21 sufficient funds to pay the Federal share of the cost of
22 construction of such project are available from the allotment
23 to the State, and if the Secretary finds (1) that the appli-
24 cation contains such reasonable assurances as to title, finan-
25 cial support, and payment of prevailing rates of wages and

1 overtime pay, (2) that the plans and specifications are in
2 accord with regulations prescribed by the Secretary, (3)
3 that the application is in conformity with the State plan
4 approved under this part, and (4) that the application has
5 been approved and recommended by the State agency desig-
6 nated in accordance with section 134 (b) (1) (C) and is
7 entitled to priority over other projects within the State in
8 accordance with the State's plan for persons with develop-
9 mental disabilities and in accordance with regulations pre-
10 scribed by the Secretary.

11 “(c) No application shall be disapproved until the
12 Secretary has afforded the State agency an opportunity for
13 a hearing.

14 “(d) Amendment of any approved application shall be
15 subject to approval in the same manner as the original
16 application.

17 “WITHHOLDING OF PAYMENTS FOR CONSTRUCTION

18 “SEC. 136. (a) Whenever the Secretary, after reasonable
19 notice and opportunity for hearing to the State agency (desig-
20 nated in accordance with section 134 (b) (1) (C)) of any
21 State, finds that—

22 “(1) the State agency is not complying substan-
23 tially with the provisions required by section 134 (b)
24 to be included in the State plan, or with regulations of
25 the Secretary,

1 “(2) any assurance required to be given in an
2 application filed under section 135 is not being or can-
3 not be carried out,

4 “(3) there is a substantial failure to carry out
5 plans and specifications related to construction approved
6 by the Secretary under section 134, or

7 “(4) adequate funds are not being provided annual-
8 ly for the direct administration of the State plan,
9 the Secretary may forthwith withhold payments for con-
10 struction from the allotment of such State in accordance with
11 subsection (b).

12 “(b) If the Secretary makes a finding described in sub-
13 section (a), he may forthwith notify the State agency that—

14 “(1) no further payments will be made to the
15 State for construction from allotments under this part,
16 or

17 “(2) no further payments will be made from allot-
18 ments under this part for any construction project or
19 projects designated by the Secretary as being affected by
20 the action or inaction referred to in paragraph (1), (2),
21 (3), or (4) of subsection (a),

22 as the Secretary may determine to be appropriate under
23 the circumstances; and, except with regard to any project
24 for which the application has already been approved and
25 which is not directly affected, further payments for con-

1 struction projects may be withheld, in whole or in part,
2 until there is no longer any failure to comply (or to carry
3 out the assurance or plans and specifications or to provide
4 adequate funds, as the case may be) or, if such compliance
5 (or other action) is impossible, until the State repays or
6 arranges for the repayment of Federal moneys to which the
7 recipient was not entitled.

8 "GRANTS TO THE STATES FOR PLANNING AND SERVICES

9 "SEC. 137. (a) (1) To carry out the purposes of section
10 130 (1), the Secretary shall make grants under this section
11 to assist the States in meeting the costs of (A) developing
12 and administering their State plans, and (B) compensation
13 of personnel to provide, in accordance with approved State
14 plans, services for persons with developmental disabilities.
15 Grants under this section with respect to any such service
16 provided under a State plan may be made only for the
17 period beginning with the first day of the first month for
18 which such a grant is made and ending with the close of
19 six years and three months after such first day.

20 "(2) A grant under this section may be made only to a
21 State which (A) has a State plan approved under this part,
22 and (B) has made an application for such grant in accord-
23 ance with regulations of the Secretary. For each of the fiscal
24 years ending June 30, 1971, June 30, 1972, and June 30,
25 1973, a grant to a State under this section shall be made from

1 the portion of the State's allotment under section 132 which
2 is not designated in its State plan for construction purposes.
3 For the fiscal year ending June 30, 1974, and each of the
4 next six fiscal years, a grant to a State under clause (B)
5 of paragraph (1) of this subsection shall be made from
6 funds appropriated under section 131 (b).

7 “(b) (1) A grant under this section for any fiscal year
8 to assist a State in meeting the costs of developing and ad-
9 ministering its State plan may not exceed 3 per centum of
10 the State's allotment under section 132 for that fiscal year
11 or \$75,000, whichever is less.

12 “(2) A grant under this section to assist a State in
13 meeting the costs of compensation of personnel to provide a
14 service for persons with developmental disabilities may not
15 exceed (A) 75 per centum of such costs for the first fifteen
16 months after the first day of the first month for which a grant
17 is made to such State for such costs, (B) 60 per centum of
18 such costs for the first year thereafter, (C) 45 per centum of
19 such costs for the second year thereafter, and (D) 30 per
20 centum of such costs for the third, fourth, and fifth years
21 thereafter. For the purpose of determining the costs of a
22 State for compensation of such personnel, costs of a political
23 subdivision thereof or of a nonprofit private agency for com-
24 pensation of such personnel shall, subject to such limitations

1 and conditions as may be prescribed by the Secretary by
2 regulation, be regarded as costs of such State.

3 “(c) Payment of grants under this section may be made
4 (after necessary adjustment on account of previously made
5 overpayments or underpayments) in advance or by way of
6 reimbursement, and on such terms and conditions, as the Sec-
7 retary may determine.

8 “WITHHOLDING OF PAYMENTS FOR PLANNING AND SERVICE

9 “SEC. 138. Whenever the Secretary, after reasonable
10 notice and opportunity for hearing to the State planning
11 and advisory council (designated in accordance with section
12 134 (b) (1) (A)) finds that—

13 “(1) there is a failure to comply substantially with
14 any of the provisions required by section 134 to be in-
15 cluded in the State plan, or

16 “(2) there is a failure to comply substantially with
17 any regulations of the Secretary which are applicable
18 to this part,

19 the Secretary shall notify such State council that further pay-
20 ments for planning or services will not be made to the State
21 under section 137 (or, in his discretion, that further pay-
22 ments for planning or services will not be made to the State
23 under that section for activities in which there is such fail-
24 ure), until he is satisfied that there will no longer be such

1 failure. Until he is so satisfied, the Secretary shall make no
2 further payment under that section to the State, or shall limit
3 further payment under that section to such State to activities
4 in which there is no such failure.

5 "REGULATIONS

6 "SEC. 139. Not later than March 1, 1970, the Secretary,
7 after consultation with the Council, by general regulations
8 applicable uniformly to all the States, shall prescribe—

9 "(1) the kinds of services which are needed to
10 provide adequate programs for persons with develop-
11 mental disabilities, the kinds of services for which assist-
12 ance may be provided under this part, and the categories
13 of persons for whom such services may be provided;

14 "(2) standards as to the scope and quality of serv-
15 ices which must be provided for persons with develop-
16 mental disabilities under a State plan approved under
17 this part;

18 "(3) the general manner in which a State, in carry-
19 ing out its State plan approved under this part, shall
20 determine priorities for services and facilities based on
21 type of service, categories of persons to be served, and
22 type of disability, with special consideration being given

1 to the needs for such services and facilities in areas of
2 urban and rural poverty; and

3 “(4) general standards of construction and equip-
4 ment for facilities of different classes and in different
5 types of location.

6 “NONDUPLICATION

7 “SEC. 140. (a) In determining the amount of any pay-
8 ment for the construction of any facility under a State plan
9 approved under this part, there shall be disregarded (1) any
10 portion of the costs of such construction which are financed
11 by Federal funds provided under any provision of law other
12 than this part, and (2) the amount of any non-Federal
13 funds required to be expended as a condition of receipt of
14 such Federal funds.

15 “(b) In determining the amount of any grant under
16 section 137 to assist a State in meeting the costs of planning
17 and of compensation of personnel, there shall be disregarded
18 (1) any portion of such costs which are financed by Federal
19 funds provided under any provision of law other than this
20 part, and (2) the amount of any non-Federal funds required
21 to be expended as a condition of receipt of such Federal
22 funds.”

1 SEC. 102. (a) Section 401 of the Mental Retardation
2 Facilities and Community Mental Health Centers Construc-
3 tion Act of 1963 (42 U.S.C. 2691) is amended by—

4 (1) inserting “the Trust Territory of the Pacific
5 Islands,” after “American Samoa,” in subsection (a) ;

6 (2) amending subsection (b) to read as follows:

7 “(b) The term ‘facility for the developmentally dis-
8 abled’ means a facility, or a specified portion of a facility,
9 designed primarily for the delivery of one or more services
10 to persons affected by one or more developmental dis-
11 abilities.”;

12 (3) striking out “mentally retarded” wherever it
13 occurs in subsection (d) and inserting “developmentally
14 disabled” in lieu thereof;

15 (4) striking out “August 31” in subsection (j) (1)
16 and inserting in lieu thereof “September 30”; and

17 (5) adding at the end of the section the follow-
18 ing subsections:

19 “(1) The term ‘developmental disability’ means a dis-
20 ability attributable to mental retardation, cerebral palsy,
21 epilepsy, or a neurological impairment of an individual
22 which originates before such individual attains age eighteen,
23 which has continued or can be expected to continue indefi-
24 nitely, and which constitutes a substantial handicap to such
25 individual.

1 “(m) The term ‘services for persons with developmental
2 disabilities’ means specialized services or special adaptations
3 of generic services directed toward the alleviation of a devel-
4 opmental disability or toward the social, personal, physical, or
5 economic habilitation or rehabilitation of an individual
6 affected by such a disability, and such term includes diag-
7 nosis, evaluation, treatment, personal care, day-care, domi-
8 ciliary care, special living arrangements, training, education,
9 sheltered employment, recreation, counseling of the individual
10 affected by such disability and of his family, protective and
11 other social and socio-legal services, and information and
12 referral services.

13 “(n) The term ‘regulations’ means (unless the text
14 otherwise indicates) regulations promulgated by the Secre-
15 tary.”

(b) Sections 403 and 405 of such Act are amended by inserting “or the developmentally disabled” after “mentally retarded” wherever it occurs.

EFFECTIVE DATE

SEC. 103. The amendments made by this title shall apply with respect to fiscal years beginning after June 30, 1970. Funds appropriated before June 30, 1970, under part C of the Mental Retardation Facilities Construction Act shall remain available for obligation during the fiscal year ending June 30, 1971.

1 TITLE II—AMENDMENTS TO PART B OF THE
2 MENTAL RETARDATION FACILITIES CON-
3 STRUCTION ACT

4 CONSTRUCTION GRANTS

5 SEC. 201. (a) The first sentence of section 121 (a) of
6 the Mental Retardation Facilities Construction Act is
7 amended—

8 (1) by striking out “clinical facilities providing, as
9 nearly as practicable, a full range of inpatient and out-
10 patient services for the mentally retarded (which for
11 purposes of this part, includes other neurological handi-
12 capping conditions found by the Secretary to be suffi-
13 ciently related to mental retardation to warrant inclu-
14 sion in this part) and”;

15 (2) by striking out “clinical training” and inserting
16 in lieu thereof: “interdisciplinary training”; and

17 (3) by striking out “each for the fiscal year ending
18 June 30, 1969, and the fiscal year ending June 30,
19 1970” and inserting in lieu thereof: “for each of the next
20 five fiscal years”.

21 (b) Section 121 of such Act is amended by adding at
22 the end thereof the following subsection:

23 “(c) For purposes of this part, the term ‘mentally re-
24 tarded’ shall include mental retardation and other neurolog-
25 ical handicapping conditions found by the Secretary to be

1 sufficiently related to mental retardation to warrant inclu-
2 sion in this part."

3 DEMONSTRATION AND TRAINING GRANTS

4 SEC. 202. Part B of the Mental Retardation Facilities
5 Construction Act is amended by redesignating sections 122,
6 123, 124, and 125 as sections 123, 124, 125, and 126,
7 respectively, and by adding the following new section after
8 section 121:

9 "DEMONSTRATION AND TRAINING

10 "SEC. 122. (a) For the purpose of assisting institutions
11 of higher education to contribute more effectively to the solu-
12 tion of complex health, education, and social problems of
13 children and adults suffering from mental retardation, the
14 Secretary may, in accordance with the provisions of this part,
15 make grants to cover costs of administering and operating
16 demonstration facilities and interdisciplinary training pro-
17 grams for personnel needed to render specialized services to
18 the mentally retarded, including established disciplines as
19 well as new kinds of training to meet critical shortages in the
20 care of the mentally retarded.

21 "(b) For the purpose of making grants under this sec-
22 tion, there are authorized to be appropriated \$10,000,000 for
23 the fiscal year ending June 30, 1971; \$12,000,000 for the
24 fiscal year ending June 30, 1972; and \$15,000,000 for the
25 fiscal year ending June 30, 1973."

SEC. 206. Part B of such Act is amended by adding at the end thereof the following new section:

1 "MAINTENANCE OF EFFORT

2 "SEC. 126. Applications for grants under this part may
3 be approved by the Secretary only if the application con-
4 tains or is supported by reasonable assurances that the grants
5 will not result in any decrease in the level of State, local, and
6 other non-Federal funds for mental retardation services and
7 training which would (except for such grant) be available
8 to the applicant, but that such grants will be used to supple-
9 ment, and, to the extent practicable, to increase the level
10 of such funds."

11 CONFORMING AMENDMENT

12 SEC. 207. (a) (1) The caption to part B of the Mental
13 Retardation Facilities Construction Act is amended to read
14 as follows:

15 "CONSTRUCTION, DEMONSTRATION AND TRAINING GRANTS
16 FOR UNIVERSITY-AFFILIATED MENTAL RETARDATION
17 FACILITIES".

[H.R. 15968, 91st Congress, 2d session, introduced by Mr. Waldie on February 17, 1970, and
H.R. 16735, 91st Congress, 2d session, introduced by Mr. Donohue on April 2, 1970,
are identical as follows:]

A BILL

To assist the States in developing a plan for the provision of comprehensive services to persons affected by mental retardation and other developmental disabilities originating in childhood, to assist the States in the provision of such services in accordance with such plan, to assist in the construction of facilities to provide the services needed to carry out such plan, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

SHORT TITLE

SECTION 1. This Act may be cited as the "Developmental Disabilities Services and Facilities Construction Act of 1969."

1 TITLE I—GRANTS FOR PLANNING, PROVISION OF
2 SERVICES, AND CONSTRUCTION OF FACILI-
3 TIES FOR PERSONS WITH DEVELOPMENTAL
4 DISABILITIES

5 SEC. 101. Part C of the Mental Retardation Facilities
6 Construction Act, as amended, is amended by striking out
7 sections 131 through 137 and substituting the following:

8 "PART C—GRANTS FOR PLANNING, PROVISION OF SERV-
9 ICES, AND CONSTRUCTION OF FACILITIES FOR PER-
10 SONS WITH DEVELOPMENTAL DISABILITIES

11 "DECLARATION OF PURPOSE

12 "SEC. 130. The purpose of this part is—

13 "(a) to make grants to assist the several States in
14 developing and implementing a comprehensive and
15 continuing plan for meeting the current and future needs
16 for services to persons affected by developmental dis-
17 abilities; and

18 "(b) to make grants to assist public and nonprofit
19 agencies in the construction of facilities for the provision
20 of services to persons affected by developmental dis-
21 abilities.

22 "AUTHORIZATION OF APPROPRIATIONS

23 "SEC. 131. In order to make the grants to carry out the
24 provisions of section 130, there are authorized to be appro-
25 priated \$100,000,000 for the fiscal year ending June 30,

1 1971, \$150,000,000 for the fiscal year ending June 30, 1972,
2 \$200,000,000 for the fiscal year ending June 30, 1973,
3 \$250,000,000 for the fiscal year ending June 30, 1974, and
4 \$250,000,000 for the fiscal year ending June 30, 1975.

5 "STATE ALLOTMENTS

6 "SEC. 132. (a) (1) From the sums appropriated to
7 carry out the purposes of section 130 for each fiscal year,
8 the several States shall be entitled to allotments determined,
9 in accordance with regulations, on the basis of (A) the pop-
10 ulation, (B) the extent of need for services and facilities
11 for persons with developmental disabilities, and (C) the
12 financial need of the respective States; except that the allot-
13 ment of any State (other than the Virgin Islands, American
14 Samoa, Guam, and the Trust Territory of the Pacific
15 Islands) for any such fiscal year shall not be less than
16 \$100,000.

17 "(2) In determining, for purposes of paragraph (1),
18 the extent of need in any State for services and facilities
19 for persons with developmental disabilities, the Secretary
20 shall take into account the scope and extent of the services
21 specified, pursuant to section 134 (b) (4), in the State plan
22 of such State approved under this part.

23 "(3) Sums allotted to a State for a fiscal year and
24 designated by it for construction and remaining unobligated
25 at the end of such year shall remain available to such State

1 for such purpose for the next fiscal year (and for such year
2 only), in addition to the sums allotted to such State for
3 such next fiscal year: *Provided*, That whenever the State
4 plan calls for the construction of a specific facility the Fed-
5 eral share of which will exceed the State's maximum per-
6 missible allotment for construction for the fiscal year, the
7 Secretary may, on the request of the State, provide that funds
8 allotted to the State remain available, to the extent neces-
9 sary but not to exceed two additional years, to be combined
10 with subsequent allotments for the specified purpose.

11 “(b) Whenever the State plan developed in accordance
12 with section 134 provides for participation of more than one
13 State agency in administering or supervising the administra-
14 tion of designated portions of the State plan, the State may
15 apportion its allotment among such agencies in a manner
16 which, to the satisfaction of the Secretary, is reasonably re-
17 lated to the responsibilities assigned to such agencies in
18 carrying out the purposes of this part. Funds so apportioned
19 to State agencies may be combined with other State or
20 Federal funds authorized to be spent for other purposes,
21 provided the purposes of this part will receive proportionate
22 benefit from the combination.

23 “(c) The amount of an allotment to a State for a fiscal
24 year which the Secretary determines will not be required by
25 the State during the period for which it is available for the

1 purpose for which allotted shall be available for reallocation
2 by the Secretary from time to time, on such date or dates
3 as he may fix, to other States with respect to which such a
4 determination has not been made, in proportion to the
5 original allotments of such States for such fiscal year, but
6 with such proportionate amount for any of such other States
7 being reduced to the extent it exceeds the sum the Secretary
8 estimates such State needs and will be able to use during
9 such period; and the total of such reductions shall be similarly
10 reallocated among the States whose proportionate amounts
11 were not so reduced. Any amount so reallocated to a State
12 for a fiscal year shall be deemed to be a part of its allotment
13 under subsection (a) for such fiscal year.

14 "NATIONAL ADVISORY COUNCIL ON SERVICES AND FACILI-
15 TIES FOR THE DEVELOPMENTALLY DISABLED

16 "SEC. 133. (a) (1) There is hereby established a Na-
17 tional Advisory Council on Services and Facilities for the
18 Developmentally Disabled (hereinafter referred to as the
19 'Council'), which shall consist of twelve members, not other-
20 wise in the regular full-time employ of the United States,
21 to be appointed by the Secretary without regard to the pro-
22 visions of title 5, United States Code, governing appoint-
23 ments in the competitive civil service.

24 "(2) The Secretary shall from time to time designate

1 one of the members of the Council to serve as Chairman
2 thereof.

3 “(3) The members of the Council shall be selected from
4 leaders in the fields of service to the mentally retarded and
5 other developmentally disabled persons, in State or local
6 government, and in organizations representing consumers of
7 such services. At least four members shall be representative
8 of State or local agencies responsible for services to the de-
9 velopmentally disabled, and at least four shall be represent-
10 ative of the interests of consumers of such services.

11 “(b) Each member of the Council shall hold office for a
12 term of four years, except that any member appointed to fill
13 a vacancy occurring prior to the expiration of the term for
14 which his predecessor was appointed shall be appointed for
15 the remainder of such term, and except that, of the twelve
16 members first appointed, three shall hold office for a term of
17 three years, three shall hold office for a term of two years,
18 and three shall hold office for a term of one year, as desig-
19 nated by the Secretary at the time of appointment.

20 “(c) It shall be the duty and function of the Council to
21 (1) advise the Secretary with respect to any regulations
22 promulgated or proposed to be promulgated by him in the
23 implementation of this title, and (2) study and evaluate
24 programs authorized by this title with a view to determining

1 their effectiveness in carrying out the purposes for which
2 they were established.

3 “(d) The Council is authorized to engage such technical
4 assistance as may be required to carry out its functions, and
5 the Secretary shall, in addition, make available to the Council
6 such secretarial, clerical, and other assistance and such statis-
7 tical and other pertinent data prepared by or available to the
8 Department of Health, Education, and Welfare as it may
9 require to carry out such functions.

10 “(e) Members of the Council, while attending meetings
11 or conferences thereof or otherwise serving on the business
12 of the Council, shall be entitled to receive compensation
13 at rates fixed by the Secretary, but not exceeding \$100 per
14 day and, while so serving away from their homes or regular
15 places of business, they may be allowed travel expenses, in-
16 cluding per diem in lieu of subsistence, as authorized by sec-
17 tion 5703 of title 5, United States Code, for persons in the
18 Government service employed intermittently.

19 “STATE PLANS

20 “SEC. 134. (a) Any State desiring to take advantage
21 of this part must have a State plan submitted to and ap-
22 proved by the Secretary under this section.

23 “(b) In order to be approved by the Secretary under

1 this section, a State plan for the provision of services and
2 facilities for persons with developmental disabilities must—

3 “(1) designate (A) a State planning and advisory
4 council, to be responsible for submitting revisions of the
5 State plan and transmitting such reports as may be re-
6 quired by the Secretary; (B) the State agency or agen-
7 cies which may administer or supervise the administra-
8 tion of all or designated portions of the State plan; and
9 (C) a single State agency as the sole agency for ad-
10 ministering or supervising the administration of grants
11 for construction under the State plan;

12 “(2) set forth policies and procedures for the ex-
13 penditure of funds under the plan, which, in the judg-
14 ment of the Secretary, are designed to assure effective
15 continuing State planning, evaluation, and delivery of
16 services (both public and private) for persons with de-
17 velopmental disabilities;

18 “(3) contain or be supported by assurances satis-
19 factory to the Secretary that (i) the funds paid to the
20 State under this part will be used to make a significant
21 contribution toward strengthening services for persons
22 with developmental disabilities in the various political
23 subdivisions of the State in order to improve the quality,
24 scope, and extent of such services; (ii) part of such funds
25 will be made available to other public or nonprofit pri-

1 vate agencies, institutions, and organizations; (iii) such
2 funds will be used to supplement and, to the extent prac-
3 ticable, to increase the level of funds that would other-
4 wise be made available for the purposes for which the
5 Federal funds are provided and not to supplant such non-
6 Federal funds; and (iv) there will be reasonable State
7 financial participation in the cost of administering and
8 implementing the State plan;

9 “(4) (A) provide for the furnishing of a range of
10 services and facilities for persons with developmental
11 disabilities associated with mental retardation, (B)
12 specify the other categories of developmental disabilities
13 which will be included in the State plan, and (C)
14 describe the quality, extent and scope of such services as
15 will be provided to persons with mental retardation and
16 other developmental disabilities;

17 “(5) provide that services and facilities furnished
18 under the plan for persons with developmental disabili-
19 ties will be in accordance with standards prescribed by
20 regulations, including standards as to the scope and qual-
21 ity of such services and the maintenance and operation
22 of such facilities;

23 “(6) provide such methods of administration (in-
24 cluding methods relating to the establishment and main-

1 tenance of personnel standards on a merit basis, except
2 that the Secretary shall exercise no authority with re-
3 spect to the selection, tenure of office, and compensation
4 of any individual employed in accordance with such
5 methods) as are found by the Secretary to be necessary
6 for the proper and efficient operation of the plan;

7 “(7) provide that the State planning and advisory
8 council shall be adequately staffed, shall include repre-
9 sentatives of each of the principal State agencies and
10 representatives of local agencies and nongovernmental
11 organizations and groups concerned with services for per-
12 sons with developmental disabilities: *Provided*, That at
13 least one-third of the membership of such council shall
14 consist of representatives of consumers of such services;

15 “(8) provide that the State planning and advisory
16 council will from time to time, but not less often than
17 annually, review and evaluate its State plan approved
18 under this section and submit appropriate modifications
19 to the Secretary;

20 “(9) provide that the State agencies designated
21 in paragraph (1) will make such reports, in such form
22 and containing such information, as the Secretary may
23 from time to time reasonably require, and will keep such
24 records and afford such access thereto as the Secretary

1 finds necessary to assure the correctness and verification
2 of such reports;

3 “(10) provide that special financial and technical
4 assistance shall be given to areas of urban or rural pov-
5 erty in securing services and facilities for developmen-
6 tally disabled residents of such areas;

7 “(11) describe the methods to be used to assess
8 the effectiveness and accomplishments of the State in
9 meeting the needs of developmentally disabled persons
10 in the State;

11 “(12) provide for the development of a program of
12 construction of facilities for the provision of services for
13 persons with developmental disabilities which (A) is
14 based on a statewide inventory of existing facilities and
15 survey of need; and (B) which meets the requirements
16 prescribed by the Secretary for furnishing needed serv-
17 ices to persons unable to pay therefor;

18 “(13) set forth the relative need, determined in
19 accordance with regulations prescribed by the Secretary,
20 for the several projects included in the construction pro-
21 gram referred to in paragraph (12), and assign priority
22 to the construction of projects, insofar as financial re-
23 sources available therefor and for maintenance and oper-
24 ation make possible, in the order of such relative need;

1 “(14) specify the per centum of the State’s allot-
2 ment (under section 132) for any year which is to be
3 devoted to construction of facilities, which per centum
4 shall be not more than 50 per centum or such lesser per
5 centum of the allotment as the Secretary may from time
6 to time prescribe;

7 “(15) provide for affording to every applicant for
8 a construction project an opportunity for hearing before
9 the State agency;

10 “(16) provide for such fiscal control and fund
11 accounting procedures as may be necessary to assure the
12 proper disbursement of and accounting for funds paid
13 to the State under this part; and

14 “(17) contain such additional information and as-
15 surances as the Secretary may find necessary to carry
16 out the provisions and purposes of this part.

17 “(c) The Secretary shall approve any State plan and
18 any modification thereof which complies with the provisions
19 of subsection (b). The Secretary shall not finally disapprove
20 a State plan except after reasonable notice and opportunity
21 for a hearing to the State.

22 “APPROVAL OF PROJECTS FOR CONSTRUCTION

23 “SEC. 135. (a) For each project for construction pur-
24 suant to a State plan approved under this part, there shall
25 be submitted to the Secretary, through the State agency

1 designated in section 134 (b) (1) (C), an application by the
2 State or a political subdivision thereof or by a public or other
3 nonprofit agency. If two or more agencies join in the con-
4 struction of the project, the application may be filed by one
5 or more of such agencies. Such application shall set forth—

6 “(1) a description of the site for such project;

7 “(2) plans and specifications thereof, in accord-
8 ance with regulations prescribed by the Secretary;

9 “(3) reasonable assurance that title to such site
10 is or will be vested in one or more of the agencies filing
11 the application or in a public or other nonprofit agency
12 which is to operate the facility;

13 “(4) reasonable assurance that adequate financial
14 support will be available for the construction of the
15 project and for its maintenance and operation when
16 completed;

17 “(5) reasonable assurance that all laborers and
18 mechanics employed by contractors or subcontractors in
19 the performance of work on construction of the project
20 will be paid wages at rates not less than those prevail-
21 ing on similar construction in the locality as determined
22 by the Secretary of Labor in accordance with the Davis-
23 Bacon Act, as amended (40 U.S.C. 276a—276a-5);
24 and the Secretary of Labor shall have with respect to

14

1 the labor standards specified in this paragraph the au-
2 thority and functions set forth in Reorganization Plan
3 Numbered 14 of 1950 (15 F.R. 3176) and section 2 of
4 the Act of June 13, 1934, as amended (40 U.S.C.
5 276c) ; and

6 “(6) a certification by the State agency of the
7 Federal share for the project.

8 “(b) The Secretary shall approve such application if
9 sufficient funds to pay the Federal share of the cost of
10 construction of such project are available from the allotment
11 to the State, and if the Secretary finds (1) that the appli-
12 cation contains such reasonable assurances as to title, finan-
13 cial support, and payment of prevailing rates of wages and
14 overtime pay, (2) that the plans and specifications are in
15 accord with regulations prescribed by the Secretary, (3)
16 that the application is in conformity with the State plan
17 approved under this part, and (4) that the application has
18 been approved and recommended by the State agency and
19 is entitled to priority over other projects within the State in
20 accordance with the State’s plan for persons with develop-
21 mental disabilities and in accordance with regulations pre-
22 scribed by the Secretary.

23 “(c) No application shall be disapproved until the
24 Secretary has afforded the State agency an opportunity for
25 a hearing.

15

1 “(d) Amendment of any approved application shall be
2 subject to approval in the same manner as the original
3 application.

4 “WITHHOLDING OF PAYMENTS FOR CONSTRUCTION

5 “SEC. 136. Whenever the Secretary, after reasonable
6 notice and opportunity for hearing to the State agency des-
7 ignated in section 134 (b) (1) (C) finds—

8 “(a) that the State agency is not complying sub-
9 stantially with the provisions required by section 134
10 (b) to be included in the State plan, or with regulations
11 of the Secretary;

12 “(b) that any assurance required to be given in an
13 application filed under section 135 is not being or can-
14 not be carried out;

15 “(c) that there is a substantial failure to carry out
16 plans and specifications related to construction approved
17 by the Secretary under section 134; or

18 “(d) that adequate funds are not being provided
19 annually for the direct administration of the State plan,
20 the Secretary may forthwith notify the State agency that—

21 “(e) no further payments will be made to the
22 State for construction from allotments under this part;
23 or

24 “(f) no further payments will be made from allot-
25 ments under this part for any project or projects desig-

1 nated by the Secretary as being affected by the action
2 or inaction referred to in paragraph (a), (b), (c), or
3 (d) of this section;
4 as the Secretary may determine to be appropriate under
5 the circumstances; and, except with regard to any project
6 for which the application has already been approved and
7 which is not directly affected, further payments for con-
8 struction projects may be withheld, in whole or in part,
9 until there is no longer any failure to comply (or to carry
10 out the assurance or plans and specifications or to provide
11 adequate funds, as the case may be) or, if such compliance
12 (or other action) is impossible, until the State repays or
13 arranges for the repayment of Federal moneys to which the
14 recipient was not entitled.
15 "PAYMENTS TO THE STATES FOR PLANNING AND SERVICES
16 "SEC. 137. (a) (1) From each State's allotments for
17 a fiscal year under section 132, the State shall be paid the
18 Federal share of the expenditures, other than expenditures
19 for construction, incurred during such year under its State
20 plan approved under this part. Such payments shall be made
21 from time to time in advance on the basis of estimates by
22 the Secretary of the sums the State will expend under the
23 State plan, except that such adjustments as may be necessary
24 shall be made on account of previously made underpayments
25 or overpayments under this section.

1 “(2) For the purpose of determining the Federal
2 share of any State, expenditures by a political subdivision
3 thereof or by nonprofit private agencies, organizations, and
4 groups shall, subject to such limitations and conditions as
5 may be prescribed by regulations, be regarded as expendi-
6 tures by such State.

7 “(b) The ‘Federal share’ for any State for purposes
8 of this section for any fiscal year shall be 80 per centum of
9 the expenditures, other than expenditures for construction,
10 incurred by the State during such year under its State plan
11 approved under this part.

12 “WITHHOLDING OF PAYMENTS FOR PLANNING AND SERVICE

13 “SEC. 138. Whenever the Secretary, after reasonable
14 notice and opportunity for hearing to the State planning
15 and advisory council finds that—

16 “(1) there is a failure to comply substantially with
17 any of the provisions required by section 134 to be in-
18 cluded in the State plan; or

19 “(2) there is a failure to comply substantially with
20 any regulations of the Secretary which are applicable
21 to this part,

22 the Secretary shall notify such State council that further pay-
23 ments will not be made to the State under this part (or, in
24 his discretion, that further payments will not be made to the

1 State under this part for activities in which there is such fail-
2 ure), until he is satisfied that there will no longer be such
3 failure. Until he is so satisfied, the Secretary shall make no
4 further payment to the State under this part, or shall limit
5 further payment under this part to such State to activities
6 in which there is no such failure.

7 "REGULATIONS

8 "SEC. 139. Not later than March 1, 1970, the Secretary,
9 after consultation with the National Advisory Council on
10 Services and Facilities for the Developmentally Disabled
11 (established by section 133), by general regulations appli-
12 cable uniformly to all the States, shall prescribe—

13 "(1) the kinds of services which are needed to
14 provide adequate programs for persons with develop-
15 mental disabilities, the kinds of services which may be
16 provided under this part, and the categories of persons
17 for whom such services may be provided;

18 "(2) standards as to the scope and quality of serv-
19 ices which must be provided for persons with develop-
20 mental disabilities under a State plan approved under
21 this part;

22 "(3) the general manner in which a State, in carry-
23 ing out its State plan approved under this part, shall
24 determine priorities for services and facilities based on
25 type of service, categories of persons to be served, and

1 type of disability, with special consideration being given
2 to the needs for such services and facilities in areas of
3 urban and rural poverty; and

4 " (4) general standards of construction and equip-
5 ment for facilities of different classes and in different
6 types of location.

7 "NONDUPLICATION

8 "SEC. 140. (a) In determining the amount of any pay-
9 ment for the construction of any facility under a State plan
10 approved under this part, there shall be disregarded (1) any
11 portion of the costs of such construction which are financed
12 by Federal funds provided under any provision of law other
13 than this part, and (2) the amount of any non-Federal
14 funds required to be expended as a condition of receipt of
15 such Federal funds.

16 " (b) In determining the amount of any State's Federal
17 share of expenditures for planning and services incurred by it
18 under a State plan approved under this part, there shall be
19 disregarded (1) any portion of such expenditures which are
20 financed by Federal funds provided under any provision of
21 law other than this part, and (2) the amount of any non-
22 Federal funds required to be expended as a condition of
23 receipt of such Federal funds."

24 SEC. 102. (a) Section 401 of the Mental Retardation

1 Facilities and Community Mental Health Centers Construc-
2 tion Act of 1963, as amended (42 U.S.C. 2691), is amended
3 by—

4 (1) inserting “the Trust Territory of the Pacific
5 Islands” after “American Samoa” in subsection (a);

6 (2) striking out subsection (b) and inserting in
7 lieu thereof the following:

8 “(2) The term ‘facility for the developmentally dis-
9 abled’ means a facility, or a specified portion of a facility,
10 designed primarily for the delivery of one or more services
11 to persons affected by one or more developmental dis-
12 abilities.”;

13 (3) striking out the words “mentally retarded”
14 wherever they occur in subsection (d) and inserting the
15 words “developmentally disabled” in lieu thereof;

16 (4) striking out “August 31” in subsection (j) (1)
17 and inserting in lieu thereof “September 30”; and

18 (5) by adding at the end of the section the follow-
19 ing subsections:

20 “(1) The term ‘developmental disability’ means a dis-
21 ability attributable to mental retardation, cerebral palsy,
22 epilepsy, a neurological impairment, a sensory defect, or any
23 other chronic physical or mental impairment of an individual
24 which originates before such individual attains age eighteen,
25 which has continued or can be expected to continue indefi-

1 nitely, and which constitutes a substantial handicap to such
2 individual.

3 “(m) The term ‘services for persons with developmental
4 disabilities’ means specialized services or special adaptations
5 of generic services directed toward the alleviation of a devel-
6 opmental disability or toward the social, personal, physical, or
7 economic habilitation or rehabilitation of an individual
8 affected by such a disability, and such term includes diag-
9 nosis, evaluation, treatment, personal care, day-care, domi-
10 ciliary care, special living arrangements, training, education,
11 sheltered employment, recreation, counseling of the individual
12 affected by such disability and of his family, protective and
13 other social and socio-legal services and information and refer-
14 ral services.

15 “(n) The term ‘regulations’ means (unless the text
16 otherwise indicates) regulations promulgated by the Secre-
17 tary.”

18 (b) Sections 403 and 405 of such Act are amended by
19 inserting the words “or the developmentally disabled” after
20 the words “mentally retarded” wherever they occur.

21 EFFECTIVE DATE

22 SEC. 103. The amendments made by this title shall
23 apply with respect to fiscal years beginning after June 30,
24 1970: *Provided, however,* That funds appropriated prior to
25 that date under part C of the Mental Retardation Facilities

1 Construction Act shall remain available for obligation during
2 the fiscal year ending June 30, 1971.

3 TITLE II—AMENDMENTS TO PART B OF THE
4 MENTAL RETARDATION FACILITIES CON-
5 STRUCTION ACT

6 CAPTION

7 SEC. 201. (a) (1) The caption to part B of the Mental
8 Retardation Facilities Construction Act is amended to read
9 as follows:

10 “CONSTRUCTION, DEMONSTRATION AND TRAINING GRANTS
11 FOR UNIVERSITY-AFFILIATED MENTAL RETARDATION
12 FACILITIES”.

13 CONSTRUCTION GRANTS

14 SEC. 202. (a) The first sentence of section 121 (a) of
15 the Mental Retardation Facilities Construction Act is
16 amended—

17 (1) by striking out “clinical facilities providing, as
18 nearly as practicable, a full range of inpatient and out-
19 patient services for the mentally retarded (which for
20 purposes of this part, includes other neurological handi-
21 capping conditions found by the Secretary to be suffi-
22 ciently related to mental retardation to warrant inclu-
23 sion in this part) and”;

24 (2) by striking out “clinical training” and inserting
25 in lieu thereof: “interdisciplinary training”; and

1 (3) by striking out "each for the fiscal year ending
2 June 30, 1969, and the fiscal year ending June 30,
3 1970" and inserting in lieu thereof: "for each of the next
4 seven fiscal years".

5 (b) Section 121 of such Act is amended by adding at
6 the end thereof the following subsection:

7 "(c) For purposes of this part, the term 'mentally re-
8 tarded' shall include mental retardation and other neurolog-
9 ical handicapping conditions found by the Secretary to be
10 sufficiently related to mental retardation to warrant inclu-
11 sion in this part."

12 DEMONSTRATION AND TRAINING GRANTS

13 SEC. 203. Part B of the Mental Retardation Facilities
14 Construction Act is amended by redesignating sections 122,
15 123, 124, and 125 as sections 123, 124, 125, and 126,
16 respectively, and by adding the following new section after
17 section 121:

18 "SEC. 122. (a) For the purpose of assisting institutions
19 of higher education to contribute more effectively to the solu-
20 tion of complex health, education, and social problems of
21 children and adults suffering from mental retardation, the
22 Secretary may, in accordance with the provisions of this part,
23 make grants to cover costs of administering and operating
24 demonstration facilities and interdisciplinary training pro-
25 grams for personnel needed to render specialized services to

24

1 the mentally retarded, including established disciplines as
2 well as new kinds of training to meet critical shortages in the
3 care of the mentally retarded.

4 “(b) For the purpose of making grants under this sec-
5 tion, there is authorized to be appropriated \$7,000,000 for
6 the fiscal year ending June 30, 1971; \$11,000,000 for the
7 fiscal year ending June 30, 1972; \$15,000,000 for the fiscal
8 year ending June 30, 1973; and \$20,000,000 for each of the
9 next two fiscal years.

10 SEC. 204. Section 123 of such Act, as redesignated by
11 this Act is, amended by inserting “(a)” after “SEC. 122,”
12 by inserting “the construction of” before “any facility,” and
13 by adding the following new subsection at the end thereof:

14 “(b) Applications for demonstration or training grants
15 under this part may be approved by the Secretary only if
16 the applicant is a college or university operating a facility
17 of the type described in section 121, or is a public nonprofit
18 agency or organization operating such a facility.”

19 SEC. 205. Section 124 of such Act, as redesignated by
20 this Act, is amended by deleting the phrases “for the con-
21 struction of a facility” and “of construction” in subsection
22 (a) thereof, and by deleting the phrase “in such installments
23 consistent with construction progress,”.

24 SEC. 306. Section 125 of such Act, as redesignated by

25

1 this Act, is amended by inserting "construction" before
2 "funds" in the first line thereof.

3 MAINTENANCE OF EFFORT

4 SEC. 307. Such Act is amended by adding at the end
5 thereof the following new section:

6 "SEC. 126. Applications for grants under this part may
7 be approved by the Secretary only if the application con-
8 tains or is supported by reasonable assurances that the grants
9 will not result in any decrease in the level of State, local, and
10 other non-Federal funds for mental retardation services and
11 training which would (except for such grant) be available
12 to the applicant, but that such grants will be used to supple-
13 ment, and, to the extent practicable, to increase the level
14 of such funds."

To assist the States in developing a plan for the provision of comprehensive services to persons affected by mental retardation and other developmental disabilities originating in childhood, to assist the States in the provision of such services in accordance with such plan, to assist in the construction of facilities to provide the services needed to carry out such plan, and for other purposes.

3	SHORT TITLE
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SECTION 1. This Act may be cited as the "Developmental Disabilities Services and Facilities Construction Act of 1970".

1 TITLE I—GRANTS FOR PLANNING, PROVISION OF
2 SERVICES, AND CONSTRUCTION AND OP-
3 ERATION OF FACILITIES FOR PERSONS
4 WITH DEVELOPMENTAL DISABILITIES

5 SEC. 101. (a) Title I of the Mental Retardation Facil-
6 ities and Community Mental Health Centers Construction
7 Act of 1963, as amended, is amended by striking out the
8 caption and substituting the following:

9 "TITLE I—SERVICES AND FACILITIES FOR
10 THE MENTALLY RETARDED AND PERSONS
11 WITH OTHER DEVELOPMENTAL DISABIL-
12 ITIES".

13 (b) Part C of the Mental Retardation Facilities Con-
14 struction Act, as amended, is amended by striking out the
15 caption and sections 131 through 137 and substituting the
16 the following:

17 "PART C—GRANTS FOR PLANNING, PROVISION OF SERV-
18 ICES, AND CONSTRUCTION AND OPERATION OF FACILI-
19 TIES FOR PERSONS WITH DEVELOPMENTAL DISABILI-
20 TIES

21 "DECLARATION OF PURPOSE

22 SEC. 130. The purpose of this part is to authorize—

23 "(a) grants to assist the several States in develop-
24 ing and implementing a comprehensive and continuing
25 plan for meeting the current and future needs for services
26 to persons with developmental disabilities;

1 “(b) grants to assist public or nonprofit private
2 agencies in the construction of facilities for the provision
3 of services to persons with developmental disabilities,
4 including facilities for any of the purposes stated in this
5 section;

6 “(c) grants for provision of services to persons with
7 developmental disabilities, including costs of operation,
8 staffing, and maintenance of facilities for persons with
9 developmental disabilities;

10 “(d) grants for State or local planning, adminis-
11 tration, or technical assistance relating to services and
12 facilities for persons with developmental disabilities;

13 “(e) grants for training of specialized personnel
14 needed for the provision of services for persons with
15 developmental disabilities, or research related thereto;
16 and

17 “(f) grants for developing or demonstrating new or
18 improved techniques for the provision of services for
19 persons with developmental disabilities.

20 “AUTHORIZATION OF APPROPRIATIONS

21 “SEC. 131. In order to make the grants to carry out the
22 purposes of section 130, there are authorized to be appro-
23 priated \$100,000,000 for the fiscal year ending June 30,
24 1971, \$125,000,000 for the fiscal year ending June 30,
25 1972, and \$150,000,000 for the fiscal year ending June 30,
26 1973.

"STATE ALLOTMENTS

1
2 "SEC. 132. (a) (1) From the sums appropriated to
3 carry out the purposes of section 130 of each fiscal year,
4 other than amounts reserved by the Secretary for projects
5 under subsection (e), the several States shall be entitled to
6 allotments determined, in accordance with regulations, on
7 the basis of (A) the population, (B) the extent of need for
8 services and facilities for persons with developmental disa-
9 bilities, and (C) the financial need, of the respective States;
10 except that the allotment of any State (other than the Vir-
11 gin Islands, American Samoa, Guam, and the Trust Terri-
12 tory of the Pacific Islands) for any such fiscal year shall not
13 be less than \$100,000 plus, if such fiscal year is later than
14 the fiscal year ending June 30, 1971, and if the sums so ap-
15 propriated for such fiscal year exceed the amount authorized
16 to be appropriated to carry out such purposes for the fiscal
17 year ending June 30, 1971, an amount which bears the same
18 ratio to \$100,000 as the difference between the amount
19 so appropriated and the amount authorized to be appropriated
20 for the fiscal year ending June 30, 1971, bears to the amount
21 authorized to be appropriated for the fiscal year ending June
22 30, 1971.

23 "(2) In determining, for purposes of paragraph (1),
24 the extent of need in any State for services and facilities for
25 persons with developmental disabilities, the Secretary shall

1 take into account the scope and extent of the services speci-
2 fied, pursuant to section 134 (b) (5), in the State plan of
3 such State approved under this part.

4 “(3) Sums allotted to a State for a fiscal year and
5 designated by it for construction and remaining unobligated
6 at the end of such year shall remain available to such State
7 for such purpose for the next fiscal year (and for such year
8 only), in addition to the sums allotted to such State for
9 such next fiscal year: *Provided*, That whenever the State
10 plan calls for the construction of a specific facility the Fed-
11 eral share of which will exceed the maximum amount which
12 may be specified pursuant to section 134 (b) (15) for con-
13 struction for the fiscal year, the Secretary may, on the request
14 of the State, provide that funds allotted to the State shall re-
15 main available, to the extent necessary but not to exceed
16 two additional years, to be combined with subsequent amounts
17 specified for meeting the Federal share of the cost of con-
18 struction of such facility.

19 “(b) Whenever the State plan approved in accordance
20 with section 134 provides for participation of more than
21 one State agency in administering or supervising the admin-
22 istration of designated portions of the State plan, the State
23 may apportion its allotment among such agencies in a man-
24 ner which, to the satisfaction of the Secretary, is reasonably
25 related to the responsibilities assigned to such agencies in

1 carrying out the purposes of this part. Funds so apportioned
2 to State agencies may be combined with other State or Fed-
3 eral funds authorized to be spent for other purposes, provided
4 the purposes of this part will receive proportionate benefit
5 from the combination.

6 “(c) Whenever the State plan approved in accordance
7 with section 134 provides for cooperative or joint effort be-
8 tween States or between or among agencies, public or pri-
9 vate, in more than one State, portions of funds allotted to
10 one or more such cooperating States may be combined in
11 accordance with the agreements between the agencies in-
12 volved.

13 “(d) The amount of an allotment to a State for a
14 fiscal year which the Secretary determines will not be re-
15 quired by the State during the period for which it is available
16 for the purpose for which allotted shall be available for re-
17 allotment by the Secretary from time to time, on such date or
18 dates as he may fix, to other States with respect to which such
19 a determination has not been made, in proportion to the
20 original allotments of such States for such fiscal year, but
21 with such proportionate amount for any of such other States
22 being reduced to the extent it exceeds the sum the Secretary
23 estimates such State needs and will be able to use during
24 such period; and the total of such reductions shall be similarly
25 reallocated among the States whose proportionate amounts

1 were not so reduced. Any amount so reallocated to a State
2 for a fiscal year shall be deemed to be a part of its allotment
3 under subsection (a) for such fiscal year.

4 “(e) Of the sums appropriated pursuant to section 131,
5 such amount as the Secretary may determine, but not more
6 than 20 per centum thereof, shall be available for grants
7 by the Secretary to public or nonprofit private agencies to
8 pay up to 90 per centum of the cost of projects for carrying
9 out the purposes of section 130 which in his judgment are
10 of special national significance because they will assist in
11 meeting the needs of the disadvantaged with developmental
12 disabilities, or will demonstrate new or improved techniques
13 for provision of services for such persons, or are otherwise
14 specially significant for carrying out the purposes of this title.

15 “NATIONAL ADVISORY COUNCIL ON SERVICES AND FACILI-
16 TIES FOR THE DEVELOPMENTALLY DISABLED

17 “SEC. 133. (a) (1) There is hereby established a Na-
18 tional Advisory Council on Services and Facilities for the
19 Developmentally Disabled (hereinafter referred to as the
20 ‘Council’), which shall consist of twenty members, not other-
21 wise in the regular full-time employ of the United States, to
22 be appointed by the Secretary without regard to the provi-
23 sions of title 5, United States Code, governing appointments
24 in the competitive civil service.

25 “(2) The Secretary shall from time to time designate

1 one of the members of the Council to serve as Chairman
2 thereof.

3 “(3) The members of the Council shall be selected from
4 leaders in the fields of service to the mentally retarded and
5 other persons with developmental disabilities, including lead-
6 ers in State or local government, in institutions of higher
7 education, and in organizations representing consumers of
8 such services. At least six members shall be representative of
9 State or local public or nonprofit private agencies responsible
10 for services to persons with developmental disabilities, and at
11 least six shall be representative of the interests of consumers
12 of such services.

13 “(b) Each member of the Council shall hold office for a
14 term of four years, except that any member appointed to fill
15 a vacancy occurring prior to the expiration of the term for
16 which his predecessor was appointed shall be appointed for
17 the remainder of such term, and except that, of the twenty
18 members first appointed, five shall hold office for a term of
19 three years, five shall hold office for a term of two years, and
20 five shall hold office for a term of one year, as designated by
21 the Secretary at the time of appointment.

22 “(c) It shall be the duty and function of the Council to
23 (1) advise the Secretary with respect to any regulations
24 promulgated or proposed to be promulgated by him in the
25 implementation of this title, and (2) study and evaluate

1 programs authorized by this title with a view to determining
2 their effectiveness in carrying out the purposes for which
3 they were established.

4 “(d) The Council is authorized to engage such technical
5 assistance as may be required to carry out its functions, and
6 the Secretary shall, in addition, make available to the Council
7 such secretarial, clerical, and other assistance and such statis-
8 tical and other pertinent data prepared by or available to the
9 Department of Health, Education, and Welfare as it may
10 require to carry out such functions.

11 “(e) Members of the Council, while attending meetings
12 or conferences thereof or otherwise serving on the business
13 of the Council, shall be entitled to receive compensation
14 at rates fixed by the Secretary, but not exceeding the per
15 diem equivalent for GS-18 of the General Schedule for each
16 day of such service, and, while so serving away from their
17 homes or regular places of business, they may be allowed
18 travel expenses, including per diem in lieu of subsistence, as
19 authorized by section 5703 of title 5, United States Code, for
20 persons in the Government service employed intermittently.

21 “STATE PLANS

22 “SEC. 134. (a) Any State desiring to take advantage
23 of this part must have a State plan submitted to and ap-
24 proved by the Secretary under this section.

1 “(b) In order to be approved by the Secretary under
2 this section, a State plan for the provision of services and
3 facilities for persons with developmental disabilities must—

4 “(1) designate (A) a State planning and advisory
5 council, to be responsible for submitting revisions of the
6 State plan and transmitting such reports as may be re-
7 quired by the Secretary; (B) the State agency or agen-
8 cies which will administer or supervise the administra-
9 tion of all or designated portions of the State plan; and
10 (C) a single State agency as the sole agency for ad-
11 ministering or supervising the administration of grants
12 for construction under the State plan;

13 “(2) describe (A) the quality, extent, and scope of
14 services being provided, or to be provided, to persons
15 with developmental disabilities under such other State
16 plans for federally assisted State programs as may be
17 specified by the Secretary, but in any case including
18 education for the handicapped, vocational rehabilitation,
19 public assistance, medical assistance, social services, ma-
20 ternal and child health, crippled children's services, and
21 comprehensive health and mental health plans, and (B)
22 how funds allotted to the State in accordance with sec-

1 tion 132 will be used to complement and augment rather
2 than duplicate or replace services and facilities for per-
3 sons with developmental disabilities which are eligible
4 for Federal assistance under such other State programs;
5 “(3) set forth policies and procedures for the ex-
6 penditure of funds under the plan, which, in the judg-
7 ment of the Secretary, are designed to assure effective
8 continuing State planning, evaluation, and delivery of
9 services (both public and private) for persons with
10 developmental disabilities;

11 “(4) contain or be supported by assurances satis-
12 factory to the Secretary that (A) the funds paid to
13 the State under this part will be used to make a sig-
14 nificant contribution toward strengthening services for
15 persons with developmental disabilities in the various
16 political subdivisions of the State in order to improve
17 the quality, scope, and extent of such services; (B)
18 part of such funds will be made available to other public
19 or nonprofit private agencies, institutions, and organiza-
20 tions; (C) such funds will be used to supplement
21 and, to the extent practicable, to increase the level of
22 funds that would otherwise be made available for the
23 purposes for which the Federal funds are provided and

1 not to supplant such non-Federal funds; and (D) there
2 will be reasonable State financial participaion in the
3 cost of carrying out the State plan;

4 “(5) (A) provide for the furnishing of services and
5 facilities for persons with developmental disabilities as-
6 sociated with mental retardation, (B) specify which,
7 if any, other categories of developmental disabilities (as
8 approved by the Secretary) will be included in the State
9 plan, and (C) describe the quality, extent, and scope
10 of such services as will be provided to eligible persons;

11 “(6) provide that services and facilities furnished
12 under the plan for persons with developmental disabili-
13 ties will be in accordance with standards prescribed by
14 regulations, including standards as to the scope and
15 quality of such services and the maintenance and opera-
16 tion of such facilities;

17 “(7) provide such methods of administration,
18 including methods relating to the establishment and
19 maintenance of personnel standards on a merit basis
20 (except that the Secretary shall exercise no authority
21 with respect to the selection, tenure of office, and com-
22 pensation of any individual employed in accordance
23 with such methods), as are found by the Secretary to
24 be necessary for the proper and efficient operation of
25 the plan;

1 “(8) provide that the State planning and ad-
2 visory council shall be adequately staffed, and shall in-
3 clude representatives of each of the principal State agen-
4 cies and representatives of local agencies and nongovern-
5 mental organizations and groups concerned with services
6 for persons with developmental disabilities: *Provided*,
7 That at least one-third of the membership of such council
8 shall consist of representatives of consumers of such
9 services;

10 “(9) provide that the State planning and ad-
11 visory council will from time to time, but not less often
12 than annually, review and evaluate its State plan ap-
13 proved under this section and submit appropriate modi-
14 fications to the Secretary;

15 “(10) provide that the State agencies desig-
16 nated in paragraph (1) will make such reports, in such
17 form and containing such information, as the Secretary
18 may from time to time reasonably require, and will keep
19 such records and afford such access thereto as the Secre-
20 tary finds necessary to assure the correctness and veri-
21 fication of such reports;

22 “(11) provide that special financial and technical
23 assistance shall be given to areas of urban or rural pov-
24 erty in securing services and facilities for persons with

1 developmental disabilities who are residents of such
2 areas;

3 “(12) describe the methods to be used to assess
4 the effectiveness and accomplishments of the State in
5 meeting the needs of persons with developmental dis-
6 abilities in the State;

7 “(13) provide for the development of a program
8 of construction of facilities for the provision of serv-
9 ices for persons with developmental disabilities which
10 (A) is based on a statewide inventory of existing facili-
11 ties and survey of need; and (B) meets the require-
12 ments prescribed by the Secretary for furnishing needed
13 services to persons unable to pay therefor;

14 “(14) set forth the relative need, determined
15 in accordance with regulations prescribed by the Secre-
16 tary, for the several projects included in the con-
17 struction program referred to in paragraph (13), and
18 assign priority to the construction of projects, insofar
19 as financial resources available therefor and for mainte-
20 nance and operation make possible, in the order of such
21 relative need;

22 “(15) specify the per centum of the State's allot-
23 ment (under section 132) for any year which is to
24 be devoted to construction of facilities, which per centum
25 shall be not more than such per centum as the Sec-
26 retary may from time to time prescribe;

1 “(16) provide for affording to every applicant
2 for a construction project an opportunity for hearing
3 before the State agency;

4 “(17) provide for such fiscal control and fund
5 accounting procedures as may be necessary to assure the
6 proper disbursement of and accounting for funds paid
7 to the State under this part; and

8 “(18) contain such additional information and
9 assurances as the Secretary may find necessary to carry
10 out the provisions and purposes of this part.

11 “(c) The Secretary shall approve any State plan and
12 any modification thereof which complies with the provisions
13 of subsection (b). The Secretary shall not finally disapprove
14 a State plan except after reasonable notice and opportunity
15 for a hearing to the State.

16 “APPROVAL OF PROJECTS FOR CONSTRUCTION

17 “SEC. 135. (a) For each project for construction pur-
18 suant to a State plan approved under this part, there shall
19 be submitted to the Secretary, through the State agency
20 designated in section 134 (b) (1) (C), an application by the
21 State or a political subdivision thereof or by a public or
22 nonprofit private agency. If two or more agencies join in the
23 construction of the project, the application may be filed by
24 one or more of such agencies. Such application shall set
25 forth—

1 “(1) a description of the site for such project;

2 “(2) plans and specifications thereof, in accord-
3 ance with regulations prescribed by the Secretary;

4 “(3) reasonable assurance that title to such site
5 is or will be vested in one or more of the agencies filing
6 the application or in a public or nonprofit private
7 agency which is to operate the facility;

8 “(4) reasonable assurance that adequate financial
9 support will be available for the construction of the
10 project and for its maintenance and operation when
11 completed;

12 “(5) reasonable assurance that all laborers and
13 mechanics employed by contractors or subcontractors in
14 the performance of work on construction of the project
15 will be paid wages at rates not less than those prevail-
16 ing on similar construction in the locality as determined
17 by the Secretary of Labor in accordance with the Davis-
18 Bacon Act, as amended (40 U.S.C. 276a—276a-5) ;
19 and the Secretary of Labor shall have with respect to
20 the labor standards specified in this paragraph the au-
21 thority and functions set forth in Reorganization Plan
22 Numbered 14 of 1950 (15 F.R. 3176; 5 U.S.C. 133z-
23 15) and section 2 of the Act of June 13, 1934, as
24 amended (40 U.S.C. 276c) ; and

1 “(6) a certification by the State agency of the
2 Federal share for the project.

3 “(b) The Secretary shall approve such application if
4 sufficient funds to pay the Federal share of the cost of
5 construction of such project are available from the allotment
6 to the State, and if the Secretary finds (1) that the appli-
7 cation contains such reasonable assurances as to title, finan-
8 cial support, and payment of prevailing rates of wages and
9 overtime pay, (2) that the plans and specifications are in
10 accord with regulations prescribed by the Secretary, (3)
11 that the application is in conformity with the State plan
12 approved under this part, and (4) that the application has
13 been approved and recommended by the State agency and
14 is entitled to priority over other projects within the State in
15 accordance with the State's plan for persons with develop-
16 mental disabilities and in accordance with regulations pre-
17 scribed by the Secretary.

18 “(c) No application shall be disapproved until the
19 Secretary has afforded the State agency an opportunity for
20 a hearing.

21 “(d) Amendment of any approved application shall be
22 subject to approval in the same manner as the original
23 application.

1 "WITHHOLDING OF PAYMENTS FOR CONSTRUCTION

2 "SEC. 136. Whenever the Secretary, after reasonable
3 notice and opportunity for hearing to the State planning and
4 advisory council designated in section 134 (b) (1) (A) and
5 the State agency designated in section 134 (b) (1) (C)
6 finds—

7 "(a) that the State agency is not complying sub-
8 stantially with the provisions required by section 134
9 (b) to be included in the State plan, or with regulations
10 of the Secretary;

11 "(b) that any assurance required to be given in an
12 application filed under section 135 is not being or can-
13 not be carried out;

14 "(c) that there is a substantial failure to carry out
15 plans and specifications related to construction approved
16 by the Secretary under section 134; or

17 "(d) that adequate funds are not being provided
18 annually for the direct administration of the State plan,
19 the Secretary may forthwith notify such State council and
20 agency that—

21 "(e) no further payments will be made to the
22 State for construction from allotments under this
23 part; or

24 "(f) no further payments will be made from allot-
25 ments under this part for any project or projects desig-

1 nated by the Secretary as being affected by the action
2 or inaction referred to in paragraph (a), (b), (c), or
3 (d) of this section;
4 as the Secretary may determine to be appropriate under
5 the circumstances; and, except with regard to any project
6 for which the application has already been approved and
7 which is not directly affected, further payments for con-
8 struction projects may be withheld, in whole or in part,
9 until there is no longer any failure to comply (or to carry
10 out the assurance or plans and specifications or to provide
11 adequate funds, as the case may be) or, if such compliance
12 (or other action) is impossible, until the State repays or
13 arranges for the repayment of Federal moneys to which the
14 recipient was not entitled.

15 "PAYMENTS TO THE STATES FOR PLANNING, ADMINISTRA-
16 TION, AND SERVICES

17 "SEC. 137. (a) (1) From each State's allotments for
18 a fiscal year under section 132, the State shall be paid the
19 Federal share of the expenditures, other than expenditures
20 for construction, incurred during such year under its State
21 plan approved under this part. Such payments shall be made
22 from time to time in advance on the basis of estimates by
23 the Secretary of the sums the State will expend under the
24 State plan, except that such adjustments as may be necessary

1 shall be made on account of previously made underpayments
2 or overpayments under this section.

3 “(2) For the purpose of determining the Federal
4 share of any State, expenditures by a political subdivision
5 thereof or by nonprofit private agencies, organizations, and
6 groups shall, subject to such limitations and conditions as
7 may be prescribed by regulations, be regarded as expendi-
8 tures by such State.

9 “(b) The ‘Federal share’ for any State for purposes
10 of this section for any fiscal year shall be 80 per centum of
11 the expenditures, other than expenditures for construction,
12 incurred by the State during such year under its State plan
13 approved under this part.

14 “WITHHOLDING OF PAYMENTS FOR PLANNING,
15 ADMINISTRATION, AND SERVICES

16 “SEC. 138. Whenever the Secretary, after reasonable
17 notice and opportunity for hearing to the State planning
18 and advisory council and the State agencies designated pur-
19 suant to section 134 (b) (1) finds that—

20 “(a) there is a failure to comply substantially
21 with any of the provisions required by section 134 to be
22 included in the State plan; or

23 “(b) there is a failure to comply substantially
24 with any regulations of the Secretary which are appli-
25 cable to this part,

21

1 the Secretary shall notify such State council and agencies
2 that further payments will not be made to the State under
3 this part (or, in his discretion, that further payments will
4 not be made to the State under this part for activities in
5 which there is such failure), until he is satisfied that there
6 will no longer be such failure. Until he is so satisfied, the
7 Secretary shall make no further payment to the State under
8 this part, or shall limit further payment under this part to
9 such State to activities in which there is no such failure.

10 "REGULATIONS

11 "SEC. 139. Not later than July 1, 1970, the Sec-
12 retary, after consultation with the National Advisory Council
13 on Services and Facilities for the Developmentally Disabled
14 (established by section 133), by general regulations appli-
15 cable uniformly to all the States, shall prescribe—

16 "(a) the kinds of services which are needed to
17 provide adequate programs for persons with develop-
18 mental disabilities, the kinds of services which may be
19 provided under a State plan approved under this part,
20 and the categories of persons for whom such services
21 may be provided;

22 "(b) standards as to the scope and quality of
23 services provided for persons with developmental dis-
24 abilities under a State plan approved under this part;

1 “(c) the general manner in which a State, in
2 carrying out its State plan approved under this part, shall
3 determine priorities for services and facilities based on
4 type of service, categories of persons to be served, and
5 type of disability, with special consideration being given
6 to the needs for such services and facilities in areas of
7 urban and rural poverty; and

8 “(d) general standards of construction and equip-
9 ment for facilities of different classes and in different
10 types of location.

11 “NONDUPLICATION

12 “SEC. 140. (a) In determining the amount of any pay-
13 ment for the construction of any facility under a State plan
14 approved under this part, there shall be disregarded (1) any
15 portion of the costs of such construction which are financed
16 by Federal funds provided under any provision of law other
17 than this part, and (2) the amount of any non-Federal
18 funds required to be expended as a condition of receipt of
19 such Federal funds.

20 “(b) In determining the amount of any State’s Federal
21 share of expenditures for planning, administration, and serv-
22 ices incurred by it under a State plan approved under this
23 part, there shall be disregarded (1) any portion of such
24 expenditures which are financed by Federal funds provided
25 under any provision of law other than this part, and (2) the

1 amount of any non-Federal funds required to be expended as
2 a condition of receipt of such Federal funds.”

3 SEC. 102. (a) Section 401 of the Mental Retardation
4 Facilities and Community Mental Health Centers Construc-
5 tion Act of 1963, as amended (42 U.S.C. 2691), is amended
6 by—

7 (1) striking out “; for purposes of this title and
8 title II only, includes the Trust Territory of the Pacific
9 Islands” in subsection (a) and inserting “the Trust
10 Territory of the Pacific Islands,” after “Virgin Islands,”;

11 (2) striking out subsection (b) and inserting in
12 lieu thereof the following:

13 “(b) The term ‘facility for persons with develop-
14 mental disabilities’ means a facility, or a specified por-
15 tion of a facility, designed primarily for the delivery of
16 one or more services to persons with one or more devel-
17 opmental disabilities.”;

18 (3) striking out the words “the mentally retarded”
19 wherever they occur in subsection (d) and inserting the
20 words “persons with developmental disabilities” in lieu
21 thereof;

22 (4) by adding at the end of the section the fol-
23 lowing subsections:

24 “(1) The term ‘developmental disability’ means a dis-

1 ability attributable to mental retardation, cerebral palsy, epi-
2 lepsy, or other neurological handicapping condition of an
3 individual which originates before such individual attains age
4 eighteen, which has continued or can be expected to continue
5 indefinitely, and which constitutes a substantial handicap to
6 such individual.

7 “(m) The term ‘services for persons with develop-
8 mental disabilities’ means specialized services or special
9 adaptations of generic services directed toward the alleviation
10 of a developmental disability or toward the social, personal,
11 physical, or economic habilitation or rehabilitation of an
12 individual affected by such a disability, and such term in-
13 cludes diagnosis, evaluation, treatment, personal care, day-
14 care, domiciliary care, special living arrangements, training,
15 education, sheltered employment, recreation, counseling of
16 the individual with such disability and of his family, protec-
17 tive and other social and socio-legal services, information and
18 referral services, follow-on services, and transportation serv-
19 ices necessary to assure delivery of services to persons with
20 developmental disabilities.

21 “(n) The term ‘regulations’ means (unless the text
22 otherwise indicates) regulations promulgated by the Secre-
23 tary.”

24 (b) Sections 403, 405, and 406 of such Act are amended
25 by inserting the words “or persons with other developmental

25

1 disabilities" after the words "mentally retarded" wherever
2 they occur.

3 (c) Section 404 of such Act is amended by deleting
4 "134 (b)" and inserting "134 (c)" in lieu thereof.

5 EFFECTIVE DATE

6 SEC. 103. The amendments made by this title shall
7 apply with respect to appropriations for fiscal years begin-
8 ning after June 30, 1970.

9 TITLE II—CONSTRUCTION, DEMONSTRATION,
10 AND TRAINING GRANTS FOR UNIVERSITY-
11 AFFILIATED FACILITIES FOR THE MEN-
12 TALLY RETARDED

13 CAPTION

14 SEC. 201. The caption to part B of the Mental Retarda-
15 tion Facilities Construction Act is amended to read as
16 follows:

17 "CONSTRUCTION, DEMONSTRATION AND TRAINING GRANTS
18 FOR UNIVERSITY-AFFILIATED FACILITIES FOR THE
19 MENTALLY RETARDED".

20 CONSTRUCTION GRANTS

21 SEC. 202. (a) The first sentence of section 121 (a) of
22 the Mental Retardation Facilities Construction Act is
23 amended—

24 (1) by striking out "clinical facilities providing, as

1 nearly as practicable, a full range of inpatient and out-
2 patient services for the mentally retarded (which for
3 purposes of this part, includes other neurological
4 handicapping conditions found by the Secretary to be
5 sufficiently related to mental retardation to warrant
6 inclusion in this part) and”;

7 (2) by striking out “clinical training” and inserting
8 in lieu thereof: “interdisciplinary training”; and

9 (3) by striking out “each for the fiscal year ending
10 June 30, 1969, and the fiscal year ending June 30,
11 1970” and inserting in lieu thereof: “for each of the next
12 five fiscal years”.

13 (b) Section 121 of such Act is amended by adding at
14 the end thereof the following subsection:

15 “(c) For purposes of this part, the term ‘mentally re-
16 tarded’ shall include mental retardation and other neurolog-
17 ical handicapping conditions found by the Secretary to be
18 sufficiently related to mental retardation to warrant inclu-
19 sion in this part.”

20 DEMONSTRATION AND TRAINING GRANTS

21 SEC. 203. Part B of the Mental Retardation Facilities
22 Construction Act is amended by redesignating sections 122,
23 123, 124, and 125 as sections 123, 124, 125, and 126,
24 respectively, and by adding the following new section after
25 section 121:

1 “DEMONSTRATION AND TRAINING GRANTS

2 “SEC. 122. (a) For the purpose of assisting institutions
3 of higher education to contribute more effectively to the solu-
4 tion of complex health, education, and social problems of
5 children and adults suffering from mental retardation, the
6 Secretary may, in accordance with the provisions of this part,
7 make grants to cover costs of administering and operating
8 demonstration facilities, and interdisciplinary training pro-
9 grams for personnel, needed to render specialized services to
10 the mentally retarded, including established disciplines as
11 well as new kinds of training to meet critical shortages in
12 the care of the mentally retarded.

13 “(b) For the purpose of making grants under this sec-
14 tion, there is authorized to be appropriated \$7,000,000 for
15 the fiscal year ending June 30, 1971; \$11,000,000 for the
16 fiscal year ending June 30, 1972; and \$15,000,000 for the
17 fiscal year ending June 30, 1973.

18 SEC. 204. Section 123 of such Act, as redesignated by
19 this Act, is amended by inserting “(a)” after “SEC. 123.”,
20 by inserting “the construction of” before “any facility,” by
21 deleting “133 (3)” and inserting “139 (d)” in lieu thereof,
22 and by adding the following new subsection at the end
23 thereof:

24 “(b) Applications for demonstration or training grants
25 under this part may be approved by the Secretary only if

1 the applicant is a college or university operating a facility
2 of the type described in section 121, or is a public or non-
3 profit private agency or organization operating such a
4 facility."

5 SEC. 205. Section 124 of such Act, as redesignated by
6 this Act, is amended by deleting the phrases "for the con-
7 struction of a facility" and "of construction" in subsection
8 (a) thereof, and by deleting the phrase "in such installments
9 consistent with construction progress," in subsection (b)
10 thereof.

11 SEC. 206. Section 125 of such Act, as redesignated by
12 this Act, is amended by inserting "construction" before
13 "funds" in the first line thereof.

14 MAINTENANCE OF EFFORT

15 SEC. 207. Such Act is amended by adding at the end
16 thereof the following new section:

17 "MAINTENANCE OF EFFORT

18 "SEC. 127. Applications for grants under this part
19 may be approved by the Secretary only if the application
20 contains or is supported by reasonable assurances that the
21 grants will not result in any decrease in the level of State,
22 local, and other non-Federal funds for mental retardation

29

- 1 facilities, services and training which would (except for such
2 grant) be available to the applicant, but that such grants will
3 be used to supplement, and, to the extent practicable, to in-
4 crease the level of such funds.”

Passed the Senate April 13, 1970.

Attest:

FRANCIS R. VALEO,

Secretary.

EXECUTIVE OFFICE OF THE PRESIDENT,
BUREAU OF THE BUDGET,
Washington, D.C., January 20, 1970.

HON. HARLEY O. STAGGERS,
*Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington, D.C.*

DEAR MR. CHAIRMAN: This is in response to your request of January 13, 1970 for the views of the Bureau of the Budget on H.R. 15160, a bill "To amend the Mental Retardation Facilities Construction Act to extend and improve the provisions thereof, and for other purposes."

As we indicated in our December 23, 1969 report to you on H.R. 6560, H.R. 15160 contains the Administration's proposals for extending and expanding the Mental Retardation Facilities and Construction Act.

Accordingly, we recommend enactment of H.R. 15160, which would be consistent with the Administration's objectives.

Sincerely yours,

WILFRED H. ROMMEL,
Assistant Director for Legislative Reference.

EXECUTIVE OFFICE OF THE PRESIDENT,
BUREAU OF THE BUDGET,
Washington, D.C., April 23, 1970.

HON. HARLEY O. STAGGERS,
*Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington, D.C.*

DEAR MR. CHAIRMAN: This is in response to your request of April 9, 1970 for the views of the Bureau of the Budget on H.R. 16736, a bill "To amend the Mental Retardation Facilities Construction Act to extend and improve the provisions thereof, and for other purposes".

This bill is identical to H.R. 15160, which embodies the Administration's proposals as submitted on December 4, 1969. Accordingly, we recommend enactment of either H.R. 15160 or H.R. 16736. Enactment of either of those bills would be consistent with the Administration's objectives.

Sincerely,

WILFRED H. ROMMEL,
Assistant Director for Legislative Reference.

EXECUTIVE OFFICE OF THE PRESIDENT,
BUREAU OF THE BUDGET,
Washington, D.C., April 28, 1970.

HON. HARLEY O. STAGGERS,
Chairman, Committee on Interstate and Foreign Commerce, House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: This is in response to your request of April 17, 1970, for the views of the Bureau of the Budget on S. 2846, a bill "To assist the States in developing a plan for the provision of comprehensive services to persons affected by mental retardation and other developmental disabilities originating in childhood, to assist the States in the provision of such services in accordance with such plan, to assist in the construction of facilities to provide the services needed to carry out such plan, and for other purposes."

On December 4, 1969, the Secretary of Health, Education, and Welfare submitted the Administration's proposals for extending and expanding the Mental Retardation Facilities Construction Act. The Administration's proposals have been introduced as identical bills—H.R. 15160 and H.R. 16736.

Accordingly, we recommend enactment of either H.R. 15160 or H.R. 16736, in lieu of S. 2846. Enactment of either H.R. 15160 or H.R. 16736 would be consistent with the Administration's objectives.

Sincerely,

WILFRED H. ROMMEL,
Assistant Director for Legislative Reference.

GENERAL ACCOUNTING OFFICE,
COMPTROLLER GENERAL OF THE UNITED STATES,
Washington, D.C., June 1, 1970.

Hon. HARLEY O. STAGGERS,
Chairman, Committee on Interstate and Foreign Commerce, House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: By letter of April 9, 1970, you requested our comments on H.R. 16736 which, if enacted, would be cited as the "Mental Retardation Services Amendments of 1969."

The bill would, among other things, authorize such sums as may be necessary for grants for services and for construction and operation of facilities for the mentally retarded. The bill would also consolidate the separate categories of grants under title I of the present act into a single program of direct grants to public or other nonprofit agencies for the purposes of providing services and facilities for the mentally retarded. Title I of the act now includes:

Direct grants to public or other nonprofit agencies or institutions for the construction of university-affiliated mental retardation clinical facilities,

Allotments to the States for grants to public or nonprofit agencies for construction of facilities for the mentally retarded, and

Direct grants to public or other nonprofit agencies for the cost of professional and technical personnel of community mental retardation facilities.

We have no special information on the advantages or disadvantages of the proposed legislation and have no recommendations as to its merits. However, we offer the following comments for the consideration of the committee.

Title II, section 202(c) of the act provides that, under certain circumstances, a specified unused portion of a State's allotment for grants for construction of community mental health centers may be transferred to its allotment under title I of the act for construction of facilities for the mentally retarded. Similarly, title I, section 132(c) of the act provides that, under certain circumstances, a specified unused portion of a State's allotment for construction of facilities for the mentally retarded may be transferred to its allotment for construction of community mental health centers. During fiscal years 1966-1969, six States transferred about \$400,000 from their allotments for mental retardation facilities (title I) to their allotments for community mental health centers (title II). During the same period, 26 States transferred about \$11 million from their community mental health center allotments (title II) to their allotments for construction of mental retardation facilities (title I).

In amending title I of the act, H.R. 16736 would eliminate allotments to States for grants to public or other nonprofit agencies for the construction of facilities for the mentally retarded. The bill, however, would not eliminate the companion section 202(c) of title II of the act. The provisions of section 202(c) would therefore appear to be in conflict with H.R. 16736 because section 202(c) would continue to provide for States transferring unused portions of their community mental health centers allotments, but the States would no longer have mental retardation facilities allotments to which the transfer could be made. Accordingly, we believe the committee should consider making appropriate amendments to the proposed legislation and/or title II of the act to either include allotments to States in H.R. 16736 so as to afford the opportunity to transfer specified portions of States' allotments between the two programs or to discontinue the transfer authority.

For consistency or clarity, the following changes to the bill should also be given consideration:

1. Sections 3 (d), (e), and (g) of H.R. 16736 require deletions in sections 402, 403, and 405 of the act which remove references to mental retardation facilities, thus relating these sections solely to community health centers. Accordingly, certain remaining phrases as "as the case may be" and "in the case of a community mental health center" no longer are applicable since no distinction between mental retardation facilities and community health centers need be made. Therefore, these phrases should be deleted.

2. Section 3(e) of H.R. 16736 would amend section 403(b) of the existing act by deleting the words "section 135 or." The word "section" should not be deleted.

3. In the proposed section 105, paragraph (2), it is believed the word "Act" should be inserted after the words "Public Health Service." Also, the present

wording of the section would require review by two State agencies. If this is not the intent, the word "and" in line 5, page 7, should be changed to "or."

Sincerely yours,

R. F. KELLER,
Assistant Comptroller General of the United States.

GENERAL ACCOUNTING OFFICE,
COMPTROLLER GENERAL OF THE UNITED STATES,
Washington, D.C., June 12, 1970.

Hon. HARLEY O. STAGGERS,
*Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington, D.C.*

DEAR MR. CHAIRMAN: By letter of April 17, 1970, you requested our comments on S. 2846, 91st Congress, which would be cited as the "Developmental Disabilities Services and Facilities Construction Act of 1970."

We have no special information as to the advantages or disadvantages of this measure and, therefore, make no comments regarding its merits.

Sincerely yours,

ELMER B. STAATS,
Comptroller General of the United States.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
Washington, D.C., January 23, 1970.

Hon. HARLEY O. STAGGERS,
*Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington, D.C.*

DEAR MR. CHAIRMAN: This is in reply to your request of January 13, 1970, for our views on H.R. 15160, a bill "To amend the Mental Retardation Facilities Construction Act to extend and improve the provisions thereof, and for other purposes."

This bill embodies the provisions of a draft bill submitted by this Department on December 4, 1969. The details of the bill are explained in a letter of the same date to the Speaker of the House of Representatives, a copy of which is enclosed. An identical letter was sent to the President of the Senate.

For the reasons stated in the enclosed letter, we urge enactment of H.R. 15160.

The Bureau of the Budget advises that enactment of this bill would be consistent with the Administration's objectives.

Sincerely,

ROBERT H. FINCH, *Secretary.*

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
Washington, D.C., December 4, 1969.

Hon. JOHN W. MCCORMACK,
*Speaker of the House of Representatives,
Washington, D.C.*

DEAR MR. SPEAKER: Enclosed herewith for consideration of the Congress is a draft bill, the "Mental Retardation Services Amendments of 1969."

This proposal would assure the continuing support of the Federal Government in providing services and expanded facilities for the mentally retarded, including special incentives to encourage these activities in areas having the most critical need.

The proposed amendments provide for consolidating the present separate categories of grants for construction of mental retardation facilities, for construction of university affiliated facilities, and for initial staffing of community mental retardation facilities into a single, more flexible program of grants to public or nonprofit agencies covering facilities and services for the mentally retarded.

This represents an effective step in helping to meet the problem to which the President called attention in his message of April 30, 1969 to the Congress on Improving the Administration of Federal Programs as follows:

"As grant-in-aid programs have proliferated, the problems of delivery have grown more acute. States, cities, and other recipients find themselves increasingly faced with a welter of overlapping programs, often involving multiple agencies and diverse criteria. This results in confusion at the local level, in the waste of time, energy and resources, and often in frustration of the intent of Congress."

Included among the activities for which grants could be made under the draft bill are the provision of services for the mentally retarded (operation grants); construction of mental retardation facilities; development and demonstration of new or improved techniques for provision of services for the mentally retarded; training of personnel to work on the various problems of the mentally retarded; and State and local planning, administration, and technical assistance.

Other major features of the bill provide that—

The maximum on the Federal share of the costs of new projects, including construction projects, shall be 75 percent except in poverty areas where 90 percent would be permitted;

The duration of support for projects providing mental retardation services is to be extended from the present 51 months to 8 years except for poverty areas where support could be granted for 10 years;

The Federal share of support for projects providing services would decline gradually, from a maximum of 75 percent in the first two years to 10 percent in the eighth year, and in poverty areas from 90 percent in the first two years to 10 percent in the tenth year;

Operational support would continue to be provided to recipients who have already received commitments for future support under the existing law;

Federal funds for all types of mental retardation projects in a State would not be less than the amounts allotted to the State in fiscal year 1970 for construction of community mental retardation facilities; and

Joint funding arrangements with other Federal programs could be entered into.

The bill further provides that, before grants are made, States must be given an opportunity to review and make recommendations on projects in their jurisdictions.

Appropriations authorizations are requested for three years for such sums as may be necessary.

We would appreciate it if you would refer the enclosed draft bill to the appropriate committee for consideration.

The Bureau of the Budget advises that enactment of this bill would be consistent with the Administration's objectives.

Sincerely,

ROBERT H. FINCH, *Secretary*.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
Washington, D.C., May 22, 1970.

HON. HARLEY O. STAGGERS,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: This letter is in response to your request for a report on H.R. 16736, a bill "To amend the Mental Retardation Facilities Construction Act to extend and improve the provisions thereof, and for other purposes."

H.R. 16736 is identical with H.R. 15160, which was covered by our report of January 23, 1970, to your Committee on that bill.

For the reasons stated in our earlier report and the letter to the Speaker of the House of Representatives which accompanied it, we recommend prompt and favorable consideration of H.R. 16736.

The Bureau of the Budget advises that enactment of this bill would be consistent with the Administration's objectives.

Sincerely,

ROBERT H. FINCH, *Secretary*.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE.

HON. HARLEY O. STAGGERS,
*Chairman, Committee on Interstate and Foreign Commerce,
 House of Representatives,
 Washington, D.C.*

DEAR MR. CHAIRMAN: This is in response to your request of April 17, 1970, for a report on S. 2846, a bill "To assist the States in developing a plan for the provision of comprehensive services to persons affected by mental retardation and other developmental disabilities originating in childhood, to assist the States in the provision of such services in accordance with such plan, to assist in the construction of facilities to provide the services needed to carry out such plan, and for other purposes."

On June 9, 1970, Assistant Secretary for Legislation, Creed C. Black, testified for the Department before your committee with respect to S. 2846 and the Administration bill, H.R. 15160. For the reasons stated in that testimony, we urge favorable action on H.R. 15160 in lieu of S. 2846.

We are advised by the Bureau of the Budget that there is no objection to the presentation of this report and that enactment of H.R. 15160 would be consistent with the Administration's program.

Sincerely,

ROBERT H. FINCH, *Secretary.*

Mr. JARMAN. Our first witness this morning will be Mr. Creed C. Black, Assistant Secretary for Legislation, Department of Health, Education, and Welfare.

It is a pleasure to welcome Mr. Black back to our committee. We will ask you to identify your associates.

**STATEMENT OF CREED C. BLACK, ASSISTANT SECRETARY FOR
 LEGISLATION, DEPARTMENT OF HEALTH, EDUCATION, AND
 WELFARE; ACCOMPANIED BY EDWARD NEWMAN, COMMIS-
 SIONER, REHABILITATION SERVICES ADMINISTRATION; AND
 DR. ROBERT I. JASLOW, DIRECTOR, DIVISION OF MENTAL
 RETARDATION**

Mr. BLACK. Thank you, Mr. Chairman.

It is a pleasure to be here again.

And I have with me this morning, on my left, Mr. Edward Newman, who is Commissioner of Rehabilitation Services Administration, and on my right Dr. Robert I. Jaslow, who is the Director of the Division of Mental Retardation.

We are here today, as you indicated in your opening statement, to discuss the progress that has been made under the Mental Retardation Facilities Construction Act and proposals for its extension and amendment.

This legislation, as you know, was initiated in 1963 with the objectives of—

- (1) stimulating the development of a network of facilities for the delivery of services to the mentally retarded;
- (2) developing needed manpower; and

(3) encouraging research into the problems of mental retardation.

In the years since 1963, progress toward those goals has been significant.

PROGRESS REPORT

Under the community mental retardation facilities program (pt. C), for example, 310 projects have been approved. When completed, they will make available modern and efficient facilities to provide services to 37,500 persons who were not being served at all and to improve services for another 45,000 persons. When the present authorization expires at the end of this month about 75 other facilities will have been funded. When completed, these facilities will provide services to an additional 20,000 persons.

Comparable progress has been recorded under part D, the program of initial staffing grants for community mental retardation facilities, which was added to the act by the Mental Retardation Amendments of 1967. These grants are available to assist in the initial staffing of both new facilities and new services in existing facilities. To date, 388 projects have been funded, providing support for staff to serve over 110,000 retarded persons. It is expected that by the end of June, 476 projects will have been funded, providing staff to serve more than 136,500 retarded individuals in their home communities.

Also financed under this act is the university-affiliated facilities program (pt. B), which provides grants to assist in the construction of facilities to offer interdisciplinary training based on exemplary models of comprehensive services to the mentally retarded. These facilities are a major resource for training professional and technical personnel needed to work with the mentally retarded, such as physicians, social workers, nurses, psychologists, special educators, therapists, and rehabilitation specialists.

Through 1969, 18 grants for university-affiliated facilities had been approved and funded; seven have been completed and eight more should be completed within the next 12 to 18 months. The facilities are coordinating their activities with other community programs, and with State residential programs for the retarded. As a broad resource for specialized training, continuing education, and the provision of exemplary service in complex cases, they fill a role in the system of mental retardation services similar to that filled by teaching hospitals in the health field or research and training centers in the field of vocation rehabilitation.

DHEW PROGRAMS FOR MENTAL RETARDATION

Before turning from this brief summary of results thus far to the question of where we go from here, Mr. Chairman, I think it is important that we put the particular legislation before this committee into the broader context of our Department's total activities in the mental retardation area.

As the members of this committee are no doubt aware, the Mental Retardation Facilities Construction Act is a key part of a much larger effort which spans the entire Department of Health, Education, and Welfare. The impressive scope of these department-wide activities was described in a report prepared for the House Appropriations Subcommittee by the Secretary's Committee on Mental Retardation.

With your permission, I should like to submit a copy of the complete report for the record of these hearings and summarize it briefly for the purpose of our discussion today.

Mr. JARMAN. The subcommittee will be glad to receive the report.

(The report entitled "Mental Retardation Activities of the Department of Health, Education, and Welfare—January 1970" is printed in full on pp. 107–194 of this hearing.)

Mr. BLACK. The Department has responded to the needs of the retarded through a broad range of approaches which include preventive services, training of personnel, facility construction, research, education, and other supportive services.

The estimated budget requested for 1971 includes \$606,970,000 for mentally retarded persons and for prevention of mental retardation with the following breakdown:

1971 BUDGET REQUEST

Services, research, education, rehabilitation-----	\$369, 970, 000
Income maintenance:	
SRS -----	86, 000, 000
SSA -----	151, 000, 000
Total, income maintenance-----	237, 000, 000
Total -----	606, 970, 000

This estimated total of \$607 million for 1971 is almost \$40 million above the comparable figure for 1970. And a substantial part of that increase, approximately \$18 million, is for services and grants. This legislation is thus only a part of the Department's total effort on behalf of mentally retarded people.

I would like to give you just a very brief idea of what types of activities are covered.

Preventive services are those rendered as a part of programs designed to reduce the incidence of mental retardation. The major activities in this area are carried on under the maternal and child health programs authorized by the Social Security Act and the preventive services programs authorized by the Public Health Service Act.

Research provides our hope for the future through prevention and early treatment of mental retardation. In 1970 and 1971, the availability of the Rubella vaccine should prevent repetition of the tragedy of the 1964 Rubella epidemic when an estimated 9,000 babies were born retarded. HEW supported the Rubella program through research, vaccine production, and wide dissemination. Basic nutritional research has revealed the harmful effects of malnutrition on the physical and behavioral development of children and should provide future guidance in diet improvement for both mothers and children as a further means of prevention. The Department is also expanding and improving its program of family planning research and services, since both the spacing of children and the number of pregnancies can affect the incidence of mental retardation.

State health departments, crippled children's agencies, and State welfare agencies use funds provided under the Social Security Act for activities 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 under our vocational rehabilitation programs in the form of medical diagnosis, physical restoration, counseling and testing during the rehabilitation process, assistance in job placement and follow-up to insure successful rehabilitation.

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; training of teachers and other educational personnel to provide education for mentally retarded children; and training of personnel in recreation and physical education activities for the mentally retarded and other handicapped children.

LEGISLATIVE CONSIDERATIONS

It is against this background, Mr. Chairman, that I now want to return to the question of extending and amending the particular legislation now before this committee. And we must begin, I think, by looking at certain economic considerations.

Even now the programs conducted under this act are funded at substantially less than the authorized level. In the last 3 fiscal years, \$191 million has been authorized under the act, but only \$62.7 million has been actually appropriated.

I want to say in all candor that, in our opinion, substantial new sums of money are not likely to be available for this program, among many others, in the immediate future because of the budgetary constraints necessitated by the urgency of stemming inflation. This administration is firmly committed to curbing inflation, and one of the most important tools at its disposal is strict control of Federal expenditures. Under such constraints, the requirement that we choose our priorities among a host of desirable programs becomes even greater.

The administration, therefore, has considered legislation for extension of the Mental Retardation Facilities Construction Act in the context not only of the needs of the program itself but of the larger administration legislative program and fiscal policies. In this context, we believe that to hold out the hope of substantial increases in expenditures for this portion of the Department's mental retardation program would raise false expectations.

Furthermore, Mr. Chairman, one of the major goals of this administration is to consolidate and simplify Federal grant programs. It should be obvious from the earlier summary of HEW programs in the area of mental retardation that a broadgauge review of all these programs is needed before committing this administration and the American taxpayers to vast new expenditures in any individual pro-

gram on a piecemeal basis. We are now in the process of undertaking such a review.

A basic point I would like to make, Mr. Chairman, is that the administration is committed not only to the continuation of mental retardation programs and services but to strengthening the quality of the projects funded and to prevention of mental retardation wherever possible. We will move ahead as fast as fiscal constraints will permit, but inevitably these constraints force choices among alternatives.

Thus, in view of the appropriations history, our present fiscal constraints, and our desire to evaluate our total approach to mental retardation, we believe it is desirable to amend the Mental Retardation Facilities Construction Act in ways that would simplify it through consolidation, make it more flexible, and encourage the use of available resources in the most effective manner.

H.R. 15160

In December of 1969, Congressmen Staggers and Springer introduced H.R. 15160 for the administration. We feel that the provisions of this bill will enable us to administer the mental retardation program in the most effective manner at this time.

Under H.R. 15160, the present separate categories of grants for construction of mental retardation facilities, for construction of university-affiliated facilities, and for initial staffing of community mental retardation facilities would be consolidated into a single program of grants to public or nonprofit agencies for facilities and services for the mentally retarded.

Authorizations of appropriations of such sums as may be necessary are provided for the next 3 fiscal years for grants for the provision of services for the mentally retarded—operation grants—construction of mental retardation facilities; development and demonstration of new or improved techniques for provision of services for the mentally retarded; training of specialized personnel to work on various problems of the mentally retarded; and State and local planning, administration, and technical assistance.

The bill provides that the maximum Federal share of the costs of new projects, including construction projects, shall be 75 percent except in poverty areas where 90 percent would be permitted. The cost of the acquisition of land would be included in the cost of construction.

In the case of projects providing mental retardation services, the maximum duration of support would be 8 years. In poverty areas, support could be granted 10 years.

The Federal share of the cost of service projects would decline gradually from a maximum of 75 percent in the first 2 years to 10 percent in the eighth year. In poverty areas the Federal share would be 90 percent in the first 2 years declining to 10 percent in the 10th year.

Operational support would continue to be provided to recipients who have already received commitments for future support under existing law. In addition, H.R. 15160 provides that Federal funds for all types of mental retardation projects in a State would not be less than the amounts allotted to the State in fiscal year 1970 for construction of community mental retardation facilities.

Before grants are made, States would be given an opportunity to review and make recommendations on projects in their jurisdictions. In the case of an application for a project in a State which has in existence a State mental retardation construction plan or a comprehensive plan relating to services for the mentally retarded, the project must be consistent with such plan or plans.

Further, H.R. 15160 provides that joint funding arrangements with other Federal programs could be entered into.

Under H.R. 15160 support could be provided on a project basis to assist States desiring to develop coordinated approaches and mechanisms for relating programs in mental retardation to the wider area of developmental disabilities. Such projects could well lay the groundwork in concept and relationship for future extension and broadening of mental retardation programs.

We believe H.R. 15160 will provide the simplification and flexibility which are needed if available resources are to be used where the need and the opportunity for effectiveness are greatest.

For instance, I think increased attention must be given to the problem of mental retardation in poverty areas.

As the President's Committee reminded us earlier this year:

No recent finding about mental retardation has had greater impact than the discovery that retardation rates soar in urban and rural low income areas. No estimate of mental retardation incidence in such neighborhoods is less than twice the national average. One inner city count of retarded persons found one-third of the total population in a several-block area functioning at retarded achievement levels.

It is increasingly clear that the urban and rural poor have been least able to effectively organize, plan, and raise sufficient funds to compete with more affluent areas for Federal support for community based services. For example, of the 310 construction projects approved under the community mental retardation facilities program, only 64 of them—or 21 percent—are located in poverty or disadvantaged areas. The primary reasons for this are (1) inadequate matching funds for construction, which has a Federal support ceiling of 66 $\frac{2}{3}$ percent and (2) inadequate operational support from all sources, Federal, State, and local.

Preferential matching for both construction and operating costs, such as that provided in H.R. 15160, will do much to provide the needed incentive and assistance for the development of adequate mental retardation services in disadvantaged areas. Also, the extended duration of Federal participation in operating costs will provide a longer period of availability of close Federal-State-local partnership and meaningful technical assistance to these local programs.

OTHER BILLS BEFORE THE SUBCOMMITTEE

I would like to comment very briefly on two other bills before this subcommittee which would amend the Mental Retardation Facilities Construction Act. H.R. 14237 and S. 2846.

These bills do embody some principles with which we are in accord. They move significantly in the direction of unified grants, a direction with which we agree and are proposing to you today. The bills also place substantial responsibility on the States, something to which this administration wholeheartedly subscribes.

If funds of the magnitude authorized in these bills were likely to be made available, we perhaps could reconcile our differences on other points. However, with present fiscal constraints, we must think in terms of funding near present levels—not at severalfold increases—for the foreseeable future.

We also have reservations in regard to expanding the Mental Retardation Facilities Construction Act to include other forms of developmental disabilities as provided in H.R. 14237 and S. 2846. In view of the current level of funding available for the program, an expansion seems inappropriate at this time. Furthermore, other programs such as crippled children's services, and vocational rehabilitation already provide support for programs which reach people with developmental disabilities.

CONCLUSION

In conclusion, Mr. Chairman, I would like to point out that the President's Committee has identified several areas in which concerted public-private effort can bring significant progress in mental retardation.

First, increasing the availability of mental retardation services, particularly in the urban and rural low-income, disadvantaged neighborhoods in which some three-fourths of the Nation's mental retardation is found;

Second, development of better manpower recruitment and training programs for work with the retarded;

Third, better, more imaginative use of existing resources, as well as broader realization and use of the resource that the retarded themselves represent; and

Fourth, development of more public-private partnerships in mental retardation programs, services, and research.

We believe that H.R. 15160 which contains the administration's proposals will help focus on these needs, and we urge its favorable consideration by this subcommittee. We would also be pleased to provide any technical assistance the subcommittee might request in its consideration of this legislation.

(The report on mental retardation activities referred to follows:)

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Mental Retardation Activities

OF THE DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE

JANUARY 1970

U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Office of the Secretary

Secretary's Committee on Mental Retardation

Washington, D.C. 20201

(107)

PREFACE

This report describes the mental retardation program activities of the Department of Health, Education, and Welfare.

Significant progress has been made during the past year in extending and expanding services to the mentally retarded. The following highlights illustrate the progress made in 1969:

More than 30,000 mentally retarded persons were rehabilitated in 1969 through the Federally-administered Vocational Rehabilitation Program. This represents an increase of 6,000 over the previous year.

Approximately 40,000 mentally retarded children received services provided by clinics supported by the Maternal and Child Health Service.

More than 48,000 mentally retarded children were enrolled in special education programs supported in part by Federal funds.

To date 301 mental retardation community facilities construction projects have been approved. These projects upon completion will serve an estimated 75,000 retarded persons.

Even so much still needs to be done. The U. S. Department of Health, Education, and Welfare stands ready to assist in this endeavor.

William F. Baxter Jr.

William F. Baxter, Jr.
Assistant to the Assistant
Secretary for Community and
Field Services

January 27, 1970

MENTAL RETARDATION ACTIVITIES OF THE
U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, 1969

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COORDINATION OF MENTAL RETARDATION PROGRAMS

Coordination is probably the most crucial factor in successful administration of mental retardation programs. This is so because mental retardation cannot be confined to any one health, education, rehabilitation or welfare program or any single disciplinary group. A total program must include a wide range of activities designed to confront the problems of mental retardation simultaneously from many vantage points.

During the 1969 fiscal year \$500 million was obligated by the Department of Health, Education, and Welfare for mental retardation programs. These programs cover most aspects of the retarded person's life. They range in diversity from maternal and infant care to income maintenance for the aged retarded. Many agencies of the Department administer programs which affect the mentally retarded; it is extremely important that these efforts be focused and targeted so as to prevent duplication and gaps in program services.

The 1962 Report of the President's Panel on Mental Retardation recognized the importance of coordination both at the national and local levels. The Report further endorsed the concept of a Departmental committee composed of agency representatives advising the Secretary on activities related to mental retardation. The concern of the Panel resulted in the strengthening of the Secretary's Committee on Mental Retardation in 1963. The Committee had previously been known as the Departmental Committee on Mental Retardation, since its establishment in March of 1955.

Over the next several years the mental retardation program of the Department was expanded and extended. In 1968, in a move designed to make the Secretary's Committee more responsive to prevailing needs the Secretary reconstituted the membership of the Committee. The membership of the Committee had previously been composed of middle level agency personnel. Through the new action the membership was altered and now included the top level executives of the Department with the Under Secretary serving as Chairman. In addition, mental retardation Regional Office Staff were also assigned to coordinate mental retardation Regional activities.

The mission of the reconstituted Secretary's Committee on Mental Retardation remains the same; i.e., the responsibility for coordination of the Department's program and activities affecting the mentally retarded.

In October 1969 the Under Secretary established a Program Advisory Committee to serve as a resource tool to the Secretary's Committee on Mental Retardation. The Program Advisory Committee has been assigned specific tasks which are designed to improve the coordination of mental retardation programs in the Department.

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 and the President's Committee on Mental Retardation in the final reports to the President.

The Regional Office Mental Retardation Coordinators have the responsibility to: assure that interagency review and consultation takes place on proposals and applications relevant to more than one agency; serve as a focal point for interested persons or organizations seeking information or consultation on Department mental retardation programs; and provide the Secretary's Committee on Mental Retardation with information on implementation of mental retardation programs in the States.

There are four subcommittees of the Secretary's Committee on Mental Retardation. They are charged with investigating and reporting periodically on activities related to their area of concern. The subcommittees are as follows: Training, International Activities, Mental Retardation Abstracts, and Research. A list of subcommittee members are shown in Appendix E.

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.

The staff of the Secretary's Committee on Mental Retardation during the year has participated in a student field placement program for several colleges. A student from Florida State University was assigned as part of his graduate field work experience for three months.

SUMMARY OF MENTAL RETARDATION ACTIVITIES

The 1970 Appropriations Act of the Department of Health, Education, and Welfare makes available \$561,519,000 for mental retardation program activities in the current fiscal year. Of this amount \$219,300,000 is to be used for income maintenance of persons who are mentally retarded.

The mental retardation activities of the Department have been arranged according to the following categories: preventive services, basic and supportive services, training of personnel, research, construction, and income maintenance.

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 Maternal and Child Health Service, Health Services and Mental Health Administration. Maternity and Infant Care Projects support programs which provide necessary health care to prospective mothers in high risk populations. By December 1969, fifty-three such projects were in operation. Grants which support screening programs for phenylketonuria (PKU) and other metabolic diseases also are awarded by the Maternal and Child Health Service. As of December 1968, forty-three States had enacted laws related to PKU, most of them making screening for this disorder mandatory.

Basic and Supportive Services

Basic and supportive services are defined as those services 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 Maternal and Child Health Services 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 the vocational rehabilitation program supported by the Rehabilitation Services Administration: medical diagnosis, physical restoration, counseling and testing during the rehabilitation process, assistance in job placement and follow-up to insure successful rehabilitation.

The Health Services and Mental Health Administration, in conjunction with the Division of Mental Retardation, Rehabilitation Services Administration, support projects for the retarded which have service components of well integrated comprehensive health programs.

The Division of Mental Retardation through its initial staffing grant program is able to provide part of the initial cost of professional and technical personnel in the operation of new

facilities or new services in existing facilities for the retarded. Over \$10 million was appropriated in fiscal year 1970 for this program.

In addition, the Division of Mental Retardation also supports two programs directed at improving the quality of State institutional care and treatment for the mentally retarded. These programs are the Hospital Improvement and Hospital Inservice Training Programs.

With the enactment of the Elementary and Secondary Education Act of 1965 (P.L. 89-10) and its subsequent amendments, has come a number of new programs and services for the mentally retarded. The mentally retarded have especially benefitted from the provisions of Title VI of the aforementioned act, which provides opportunities for local school districts to develop new and creative programs for all handicapped children.

Training of Personnel

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; and training of personnel in recreation and physical education activities for the mentally retarded and other handicapped children.

Research

The National Institutes of Health estimates that more than \$23.7 million will be devoted in fiscal year 1970 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 field 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. Title V of Public Law 90-170 provides for grants for research or demonstration projects relating to physical education or recreation for mentally retarded and other handicapped children.

The Social and Rehabilitation Service 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. Rehabilitation Research and Training Centers for the mentally retarded provide for the diagnosis, evaluation, treatment and training, vocational counseling and placement of the mentally retarded.

Research grants administered by the Maternal and Child Health Service 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

The university-affiliated facility and the community facility construction programs are administered by the Rehabilitation Services Administration.

University-affiliated facilities for the mentally retarded provides for training of physicians and other professional personnel vitally needed to work with the mentally retarded. Seventeen applications have been approved and funded under this program.

To date, 301 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.

Income Maintenance

The Social and Rehabilitation Service 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 Administration administers a program which contributes to the maintenance of the mentally retarded through the payment of monthly benefits to eligible individuals.

Membership of
THE SECRETARY'S COMMITTEE ON MENTAL RETARDATION

1969

Mr. John G. Veneman, Chairman
Under Secretary

Mrs. Patricia Reilly Hitt, Vice Chairman
Assistant Secretary for Community
and Field Services

Mr. Robert M. Ball
Commissioner of Social Security

Dr. James Allen
Commissioner of Education

Mr. Charles C. Johnson, Jr.
Administrator of Consumer Protection
and Environmental Health Service

Dr. Rogert O. Egeberg
Assistant Secretary for Health
and Scientific Affairs

Dr. Joseph English
Administrator of Health Services
and Mental Health Administra-
tion

Dr. Robert Q. Marston
Director of National
Institutes of Health

Miss Mary E. Switzer, Admin-
istrator of Social and
Rehabilitation Service

Mr. Jule Sugarman
Acting Director, Office of
Child Development

Mr. William F. Baxter, Jr.
Acting Executive Director
Secretary's Committee on
Mental Retardation

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Introduction

The Health Services and Mental Health Administration provides leadership and direction to programs and activities designed to improve physical and mental health services for all the people of the United States and to achieve the development of health care and maintenance systems adequately financed, comprehensive, interrelated and responsive to the needs of individuals and families in all socio-economic and ethnic groups.

More specifically, the Health Services and Mental Health Administration collects, analyzes, and disseminates data on births, deaths, disease incidence, health resources, and the state of the Nation's health. It plans, directs and coordinates a national effort to improve the physical health of all Americans through the development of services to promote and sustain physical health, prevent physical illnesses and provide care and treatment for physically ill persons. And, similarly, it strives to improve mental health by developing knowledge, manpower and services to promote and sustain mental health, prevent mental illness and treat and rehabilitate mentally ill persons.

I. Preventive Services

A. Prevention of Organically-based mental retardation

Rubella Immunization

The 1964-1965 rubella epidemic was the most extensive in the United States since 1943. Estimates of morbidity with this usually mild exanthematous illness are striking. Of particular importance is the large number of children (20,000) estimated to have been born with congenital rubella syndrome. The total estimated direct and indirect cost of the 1964-65 epidemic is 1.5 billion dollars. The three greatest estimated costs are for special educational services, institutional care for retarded rubella babies, and direct medical care of children with congenital rubella syndrome.

The goal of rubella control programs is to prevent congenital rubella syndrome by vaccinating children, the primary reservoir of infection. The realization of this goal will provide immeasurable humanitarian benefits accrued from reduced suffering, economic savings from reduced health care costs and savings in educational time and funds lost through school absenteeism.

The Immunization Branch of the National Communicable Disease Center is providing the leadership in the national rubella control program. Working through 68 grant-assisted State and local health department projects which serve over 93 percent of the nation's population, the Immunization Branch has collaborated with health agencies in providing (1) well-trained qualified personnel who engage in (a) planning, organizing, and promoting activities in connection with rubella immunization programs, (b) intensive public informational, educational, and motivational activities, (c) maintaining intensive epidemiologic and laboratory surveillance, (d) immunization level surveillance and (e) use of jet injector and other immunizing equipment, and (2) rubella vaccine to be used in protecting susceptible children.

Measles Immunization

The National Communicable Disease Center through its measles immunization program has all but eliminated this once common childhood disease. The number of cases now being reported is the lowest since measles reporting began early in the century (1912).

From 1963, when measles virus vaccine became available, through 1968, 33.7 million doses of vaccine have been distributed in the United States. Due to the near eradication of this disease the problems of measles-associated encephalitis, mental retardation, and deaths are diminishing.

However, there are still several urban areas in the United States where high immunity levels have not been achieved. For measles to be eradicated in the United States, the total proportion of immune children will need to be increased and maintained at relatively high levels in all socioeconomic segments of our population

INDIAN HEALTH SERVICE

The prevention of mental retardation caused by organic factors is best accomplished by continuous, comprehensive, and high quality medical care of pregnant women and their offspring throughout the prenatal, perinatal, and postnatal periods. The Indian Health Service, through its efforts to provide exemplary medical care to its 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.

The Indian Health Service provides comprehensive medical care during the prenatal, perinatal, and postnatal periods. This includes both outpatient and inpatient care for the mother and her newborn child.

In the 47 Indian 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 newborn infants, and infants with a depressed apgar score or who are born prematurely are further evaluated for PKU or other evidence of brain damage.

Where genetic counselling is indicated the Indian Health Service attempts to provide it.

The Indian Health Service 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. Otitis Media, one of the major health problems among the children in the Indian and Alaska Native population, is currently under study in an effort to identify causal factors and to program preventive and corrective measures.

The Indian Health Service 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 Federal grants-in-aid funds. The Indian Health Service through its initiation of a nurse-midwifery program in Alaska is fully utilizing all possible health staff in the prevention of mental retardation through improved care of expectant mothers and newborn infants.

Recent studies have indicated the value of child-spacing as a measure to prevent mental retardation. An active family planning program is conducted by the Indian Health Service. Family planning assistance, as one phase of the health and welfare continuum is much broader than birth control and includes infertility services as well as the promotion of responsible parenthood. In this broad concept it is implemented in the Indian Health Service. Since the inception of the family planning program in F.Y. 1965, 28,878 female Indian beneficiaries were provided with birth control services (38% of female Indian beneficiaries 15-44 years of age). In F.Y. 1969, 13,485 women were rendered birth control services with 30,888 visits to physicians.

B. Prevention of Functionally-based mental retardation

As part of the ongoing comprehensive health program on Indian reservations, mental health projects include prevention, detection, and treatment planning for functional mental retardation. The Indian Health Service is cooperatively working with Head Start Program throughout all of its areas.

II. Basic and Supportive Services

A. Foreign Quarantine Program, National Communicable Disease Center

This program has worked closely with other Federal agencies and voluntary groups to make the best possible arrangements for the reception and treatment of the mentally retarded coming to this country as immigrants.

Mental retardation is one of the conditions specified in the Immigration and Nationality Act causing an alien to be considered ineligible to receive a visa except under waiver. The program is responsible for the review of findings in such cases and the decision on waiverability and on the suitability of proposed care.

For those mentally retarded aliens admitted to the United States, the Service reviews 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.

B. Medical and Social Services for American Indians

Medical services and medical social services are provided either directly, under contract, or through State Crippled Children's Services to all Indian beneficiaries discovered to be mentally retarded.

Because of cultural barriers and transportation problems, case-finding continues to be a major problem in this area.

III. Professional Preparation

A. Indian Health Training Programs

The Indian Health Service conducts physician residency training programs in pediatrics in its hospitals at Phoenix and Anchorage. This includes clinical training in the prevention, diagnosis, treatment, and rehabilitation of mental retardation.

The Indian Health Service continues to provide both in-service 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. The Indian Health Service continues to develop and use coordinated teaching guides for hospital and public health nursing personnel, designed as aids in teaching and good health practices to maternity patients and their families.

B. Education and Training Efforts by the Federal Health Programs Service

Coping with mental retardation among its legal beneficiaries is only one of the many health responsibilities for which Federal Health Programs Service 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.

C. Training Efforts of the National Institute of Mental Health

The President's Committee on Mental Retardation recommends "greatly expanded" support and increased effort "... to attract scientists and professional specialists in education, the medical and behavioral sciences and related fields into research and service..." Since the Inservice Training Program in Mental Retardation has been transferred from the Institute, the National Institute of Mental Health supports no training program specifically focused on the field of retardation. A number of programs, however, incorporate some emphasis on the area. Residency training in basic and child psychiatry, for example, includes education in mental retardation as a standard part of the curriculum. Also, training in psychiatric social work and other behavioral science areas includes field or classroom work in mental retardation.

The training programs vary widely in mission and content. Psychiatric residencies include training in intake, diagnostic, and evaluative studies of the retarded, as well as psychotherapeutic work with the emotionally disturbed retarded and their families. Pre- and post-doctoral training in clinical and school psychology includes instruction as well.

It should be noted that the subject of retardation is an element in all under-graduate nursing education and in most of the curricula integrating psychiatric and behavioral science concepts.

In summary, mental retardation is a multifaceted program area which incorporates many of the Institute's focal concerns such as the study and remediation of learning difficulties, cultural deprivation, and the enhancement of optimal development. The breadth and ramifications of mental retardation research makes it critical to the extension of knowledge in the mental health field.

D. Partnership for Health Training Activities

The Partnership for Health Amendments of 1967 (P.L. 90-174) through Section 314(c) authorized project grants for training, studies, and demonstrations in health planning. Public and nonprofit agencies and organizations are eligible to apply for such support. During the fiscal year 1968, \$1,410,000 was obligated through the Partnership for Health Program for mental retardation training activities.

IV. Research and Development Activities

A. Research Related to Organically-Based Mental Retardation

A pilot project conducted by the Indian Health Service in cooperation with the Bureau of Indian Affairs 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. In fiscal year 1970, this will be expanded and will be involving a number of medical schools located near reservations.

A study recently completed on the Whiteriver Reservation showed a correlation between cultural and social problems and incidence of prematurity, which frequently accompanies mental retardation.

A five-year study of American Indian Congenital Malformations, carried out jointly by the Indian Health Service and the Human Genetics Branch of the National Institute of Dental Research, is in its fourth year. When completed, the study will supply data that will help to evaluate congenital defects in relation to total health status of the Indian. It will also help to identify high frequencies of specific defects due to causes which can be remedied, and will make possible racial comparisons of congenital defects which are of basic genetic interest in trying to determine the etiology of these defects.

A long-term study of a group of 643 Alaskan Eskimo children born between 1960 and 1962 is continuing under the joint sponsorship of the Arctic Health Research Laboratory and the Indian Health Service. A report on the growth, morbidity and mortality of these children presented at the American Public Health Association meeting in 1968 provided significant information on the health status of these children applicable to the prevention of mental retardation.

B. Research Concerning Functional Mental Retardation, National Institute of Mental Health

Over the past decades, the National Institute of Mental Health (NIMH) has supported a broad range of research and training projects in the field of mental retardation. In the past several years, new and reorganized agencies within the Department of Health, Education, and Welfare have enlarged their programs in mental retardation, absorbing a variety of NIMH efforts -

particularly in the areas of demonstrations, inservice training and basic research in child development. Summarized below are those research and training programs which remain as part of the Institute's overall mental health mission.

In the report MR 68: The Edge of Change, the President's Committee on Mental Retardation recommends "... intensification of research in the social and other behavioral sciences ..." to isolate and define social and cultural factors in mental retardation (p. 25). The current NIMH research effort in retardation is consonant with this recommendation, falling into three categories: (1) studies of learning, with careful attention to the special learning problems of the retarded; (2) analyses of the effects of cultural and social deprivation; and (3) studies of the behavioral and biological aspects of retardation which relate to mental health and illness.

In the area of learning, investigators are conducting a variety of analyses of the learning process as it operates among the mentally retarded, with a view toward identifying those interventions and those techniques which may facilitate the learning process. Such variables as attention span, capacity for retention, distortions of perception and visual discrimination are being scrutinized to increase the retardate's ability to absorb and profit from his experiences, and to facilitate his intellectual and social development. A specific goal of this work is to develop improved teaching methods. For example, automated teaching techniques are being used in several studies, focusing on programmed learning to develop reading and other skills. Although a number of programs involve attempts to help already damaged children, a primary emphasis overall is the prevention of retardation in high risk populations.

In studies of cultural and social deprivation, investigators are defining the role of poverty, inadequate schooling and community disorganization in causing or contributing to various forms of mental retardation. The aim here is to provide new training and educational approaches for culturally handicapped children; to teach improved child-rearing practices to parents in deprived areas; and to modify attitudes of fear and rejection of the mentally retarded among those who are themselves economically and culturally deprived. Approaches range from broad inter-disciplinary efforts to establish controlled therapeutic settings, to the development of skills such as operant conditioning among those who attempt to teach the retarded self-sufficiency, self-control, and social adjustment.

In studies of behavioral and biological aspects of retardation, investigators are concerned with developing improved techniques for diagnosing and treating those psychological and physical abnormalities found among the retarded. A major issue here is the degree to which emotional factors contribute to retardation - the role of psychopathology and personality disorganization in the retardate's patterns of functioning. As in the case of such disorders as schizophrenia, the relative contribution of biological, social, and psychological factors remains to be accurately defined.

C. Ecological Investigations Program

The Ecological Investigations Program of the National Communicable Disease Center conducted a follow-up study in Hale County, Texas, on the residual neurologic effects of western encephalitis. Twenty-three cases, from 1963 to 1966, and 23 matched controls underwent extensive neurologic, psychologic, and intelligence testing to ascertain the presence of abnormalities, particularly with reference to learning ability. Preliminary results indicated that at least five of the western encephalitis cases had residual brain damage.

A longitudinal study of 110 White River Indian families was also initiated by the Ecological Investigations Program to determine possible interactions between growth, development, and nutrition in the production of enteric and respiratory illness in infants and children.

V. Construction

A. Community Mental Health Centers

Public Law 88-164, passed in 1963, and amended in 1965, 1967 and 1968, authorizes the NIMH to finance up to two-thirds of the cost of construction of new facilities for a community mental health center or the requisition and renovation of existing facilities. The amendments of 1965 authorized the NIMH to make grants over a 51-month period to community mental health centers to meet part of the cost of compensating professional and technical personnel providing new services. To be eligible for either construction or staffing grants an applicant must present a plan for providing a program of at least five essential services, namely, inpatient, outpatient, partial hospitalization, emergency, and consultation and education. These must be offered in a comprehensive and integrated fashion to the center's community, defined as a catchment area of 75,000 to 200,000 persons. These centers, in which the mentally retarded are eligible to receive treatment and services, serve as the nucleus of the National Mental Health Program.

Working in unison with other facets of national programs in mental retardation and mental health, the NIMH assists states and communities to achieve comprehensive treatment in the community for all who need it. Prevention of mental illness in the community is one of the major objectives of the centers.

Since the passage of the Community Mental Health Centers Act, the NIMH has supported the development of 376 community mental health centers in 50 states, the District of Columbia, and Puerto Rico. The services and programs of many of these centers extend to and include mentally retarded persons. About half the states have enacted community mental health services legislation which encourages simultaneous development of community mental health and mental retardation services usually under the auspices of a county or multi-county MH-MR Board.

At the close of fiscal year 1969, 176 centers were operational. Within the year, another 50 centers will have completed construction and/or begun operation under a staffing grant. When all 376 centers are open, augmented and improved services will be available to 52 million Americans.

Many center programs have special relevance to children. Forty-two percent of funded center programs include some kind of specialized services for children; 8 percent have an identified mental retardation service. Other data from centers operating in 1968 show that in terms of direct service, school age children are being serviced in numbers at least as great as their proportion of the total population would warrant.

B. Health Facilities and Construction Service

The Health Facilities Planning and Construction Service (HFPCS) shares responsibility in the administration of two Department programs providing construction grant assistance to facilities for the mentally retarded.

The HFPCS assists the Social and Rehabilitation Service (SRS) in the administration of the programs providing construction grants for community facilities for the mentally retarded and university-affiliated facilities for the mentally retarded under Title I, Part C and Part B, respectively, of the Community Mental Health Centers and Mental Retardation Act.

More specifically, SRS reviews and approves the initial or grant approval stage of the applications for the programs concerned, while at the same time the personnel in the HFPCS regional offices provide consultative recommendations to SRS in respect to the initial stage of the application. After the initial application stage is approved by SRS, the HFPCS program assumes responsibilities for administering subsequent project management responsibilities by approving the ability of the project sponsor to provide his share of the capital needed to construct the facility; by approving the title to the site or other site interest, results of a soil investigation; and, approves the site survey for the site upon which the facility will be constructed. The HFPCS also approves several stages of design drawings, attends bid openings, and conducts inspections of the facility while it is under construction and upon its completion.

VI. Other Activities

A. Partnership for Health

The Partnership for Health Amendments of 1967 (P.L. 90-174) expanded and extended through fiscal year 1970 the authorizations contained in Sections 314(a), (b), (c), (d), and (e) of the Public Health Service Act, as amended by P.L. 89-749. Grants under Section 314 are administered through the DHEW Regional Offices.

1. Section 314(a) authorized formula grants to States for comprehensive health planning, which would include mental retardation, among other physical, mental, and environmental health concerns.
2. Section 314(b) authorized project grants for areawide comprehensive health planning (including mental retardation). Public and non-profit private agencies or organizations are eligible to apply for such support.
3. Section 314(c) authorized project grants for training, studies, and demonstrations in health planning. Public and nonprofit private agencies and organizations are eligible to apply for such support.

4. Section 314(d) authorized formula grants to States for public health and mental health services. Mental retardation programs may be supported in accord with a State's plans for health services or mental health services.

5. Section 314(e) authorized project grants for health services development. Public or nonprofit private agencies, institutions or organizations are eligible to apply for such support. Mental retardation projects (including related training) should be for service components of well-integrated comprehensive health services programs. Highest priority will be given to project applications which provide previously unavailable special health services to the mentally retarded or their families as integral parts of programs for model cities, ghettos, neighborhood health centers, family planning, or coordinated health programs.

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 has had until September 1968, a contract with the American Association on Mental Deficiency to collect current literature on mental retardation, write informative abstracts, index the literature in depth, compile annotated bibliographies on special topics and prepare critical reviews.

From 1964 to 1967 a total of 12,500 current articles, books and monographs were collected, abstracted and indexed in the Clearinghouse system. 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 added to this system.

B. Maternal and Child Health Service

With the reorganization in October 1969, the Maternal and Child Health Program of the former Children's Bureau was transferred to the Health Services and Mental Health Administration.

The concern of the Maternal and Child Health Services (MCHS) 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 as the Children's Bureau, three of the major studies produced 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 MCHS 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 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 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 appropriation for the fiscal year 1966 for this program was \$15 million; for fiscal year 1967, \$35 million; for fiscal year 1968, \$37 million; and for fiscal year 1969, \$39 million.

The Child Health Act of 1967, which is included in P.L. 90-248, the "Social Security Amendments of 1967," makes provision for the following: (1) increased authorizations for child health under Title V; (2) services for reducing infant mortality and otherwise promoting the health of mothers and children; (3) family planning services; (4) continuation of the programs of maternity and infant care project grants and of comprehensive grants for the health of preschool and school-age children; (5) new dental health service projects; (6) emphasis on early identification of health defects of children; and (7) broadening the scope of research and training authorizations. Reducing the incidence of mental retardation and improving care to mentally retarded children are among the objectives of these provisions.

The "Social Security Amendments of 1967" authorize grants to States for services to families and children receiving Aid to Families with Dependent Children (AFDC). Based on each such family's special circumstances and requirements, services are provided for assisting the family to obtain or retain capability for self-support and care, maintain and strengthen family life and foster child development. Handicapped children and their families receiving AFDC are included in this program.

I. Preventive Services

A. 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 MCH 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, for fiscal year 1967, \$30 million; for fiscal year 1968, \$30 million, and for fiscal year 1969, \$36 million. By the end of December 1968, 53 projects were in operation.

P.L. 90-248 extends the program of maternity and infant care projects until June 30, 1972, after which they become a special part of each State health services plan. The new legislation continues the intent to help reduce the incidence of mental retardation and other handicapping conditions caused by complications associated with childbearing, and in addition calls for services for helping to reduce infant and maternal mortality. It also adds authority for projects for intensive care of infants and for family planning services.

B. 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 MCHS 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 MCHS 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 MCHS 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 December 1969, 43 States had such laws, most of them making screening for PKU mandatory. The 43 States are:

Alabama	Illinois	Missouri	Oregon
Alaska	Indiana	Montana	Pennsylvania
Arkansas	Iowa	Nebraska	Rhode Island
California	Kansas	Nevada	South Carolina
Colorado	Kentucky	New Hampshire	Tennessee
Connecticut	Louisiana	New Jersey	Texas
Florida	Maine	New Mexico	Utah
Georgia	Maryland	New York	Virginia
Hawaii	Massachusetts	North Dakota	Washington
Idaho	Michigan	Ohio	West Virginia
	Minnesota	Oklahoma	Wisconsin

As more children with PKU are found, the problems relating to treatment services are receiving increased attention. Funds were 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; this study is now under way, with a number of clinics participating. 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 financed by the MCHS to discuss PKU screening and treatment problems, pathogenesis of the disease, and other relevant topics. The proceedings of this Conference have been published under the title, "Phenylketonuria and Allied Metabolic Diseases." "Recommended Guidelines for PKU Programs" have also been prepared to make known the MCHS recommendations for a comprehensive PKU program.

Interest is also increasing in metabolic diseases other than PKU that lead to mental retardation. The MCHS is continuing to support 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.

C. Lead Poisoning

In the area of prevention, increasing attention is being paid to lead poisoning. Despite present-day manufacture and use of lead-free paint, many children become mentally retarded or suffer other damage from ingestion of chips of lead-containing paint from walls and woodwork in old, dilapidated housing. A publication, "Lead Poisoning in Children," addressed to public health workers, has been prepared, suggesting a program of prevention, casefinding, follow-up of cases, and other measures to cope with this problem. Some of the Children and Youth projects have had a special interest in finding and treating children with lead poisoning.

D. Immunizations

From experience with immunization of children against diphtheria, tetanus, and pertussis, and against measles, it has been learned that special efforts need to be made to reach children in the low-income neighborhoods of many cities. To achieve the maximum effect in the rubella program, a major public health program is being conducted.

E. Familial Mental Retardation

Interest is increasing in mental retardation associated with poverty. The MCHS has published "Children of Deprivation," a report of a project at the University of Iowa dealing with this problem, and some of the MCHS supported mental retardation clinics are now showing more active concern with this cause of mental retardation.

II. Basic and Supportive Services

A. Casefinding and Screening

The MCHS has, from the beginning of its work in financing programs for retarded children, emphasized the importance of early detection and casefinding. Preference to young children as new cases has been encouraged in the clinics supported by MCHS funds. In recent years training, particularly for nurses, has emphasized the skills necessary for early detection. "A Developmental Approach to Casefinding with Special Reference to Cerebral Palsy, Mental Retardation, and Related Disorders," written by a nurse, was published in 1967 to provide a tool for developing such competency.

B. Clinical Services

Support of clinical services for mentally retarded children is one of the most important uses for MCHS mental retardation funds. 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. As of the end of November 1969, of the almost 200 mental retardation clinics in the country, the staff and services of 135 were supported in whole or in part by MCHS funds. The MCHS-supported clinics served approximately 40,000 children in fiscal year 1969. Somewhat over one-third of the children new to the program were under 5 years of age. During fiscal year 1968 and 1969, the number of MCHS-supported clinics increased; by the end of fiscal year 1969 there were 150 such clinics serving approximately 43,000 children. The total number of mental retardation clinics in the United States is now 235.

The 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 end of December 1968, 58 Children and Youth projects were in operation. These projects provide comprehensive health services for children especially those living in areas with concentrations of low-income families.

C. Crippled Children's Services

Since enactment of the Social Security Act in 1935, the Federal government, through the MCHS, 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 services.

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. In addition, the MCHS staff itself has provided some consultation to the institutions, particularly in the fields of nutrition and physical therapy and to some extent in nursing.

A recent development has been a broadening of the scope of services to give more attention to children who are both physically handicapped and mentally retarded, children who have several physical handicaps, and children with serious learning disorders. Some mental retardation clinics are showing increased interest in serving these children and a number of special clinics, financed by MCHS funds, have been set up.

Another use of Crippled Children's funds in the mental retardation field is a study and demonstration project now under way concerning the speech and language skills of mentally retarded children.

In 1966, over 20,000 children with diagnoses of various forms of mental retardation received medical services in the Crippled Children's program. The 1967 amendments to the Social Security Act require that State plans for Crippled Children's services provide for more vigorous efforts to screen and treat children with disabling conditions. This provision should result in an increase in the number of mentally retarded children identified and treated.

D. Cytogenetic and Biochemical Laboratory Programs

A new use to which some of the MCHS 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 December 1968, 20 such projects had been approved. 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.

E. Dental Programs

Programs for the dental care of handicapped children, including the mentally retarded, have been encouraged in the past; but dental care will be given new support as a result of the 1967 Social Security Amendments. These amendments authorize support of up to 75 percent of the cost of projects to provide comprehensive dental health services for children from low-income families. No appropriation for this program was made for fiscal year 1969.

III. Training of Personnel

A. Training for Health Services

Training activities for health services in the field of mental retardation, assisted by MCHS funds, have encompassed many approaches: Grants for fellowships; support of and participation in institutes, conferences, and other short-term training sessions; consultation on course curricula; arrangements for clinical experience in mental retardation clinics; distribution of informational materials to professional workers; and recently support of the university-affiliated centers being constructed under authority of P.L. 88-164, Title I, Part B.

The new Section 511 of the Social Security Act as amended in 1967 replaces and expands the training authority to include all personnel involved in providing health care and related services to mothers and children, with special attention to undergraduate training. This amount, supplemented by special project funds from the MCH and CC programs, was used primarily to develop and support programs of interdisciplinary training in 22 universities. These university-affiliated programs are developing a variety of training approaches for the many disciplines involved in caring for the retarded children.

NATIONAL INSTITUTES OF HEALTH

Introduction

Mental retardation is a major social, educational and economic problem. Although accurate figures are not available it is estimated that 3% of the population or some six million adults and children in the United States are considered mentally retarded. An additional 20 million persons and their immediate families share their problems in coping with a society which only in the last decade has begun to attempt to understand their special needs and to seek solutions to their problems in a meaningful way. Recognition of the needs and rights of the mentally retarded and the research engendered by this recognition will ultimately result in great reduction in the hundreds of millions of dollars expended annually in this country on welfare and maintenance services.

Biomedical research now in progress has provided clues concerning the basic mechanisms involved in a number of diseases causing mental retardation. An increasing number of genetically determined conditions can now be diagnosed in utero. Management of these cases in utero is the subject of research in a number of research centers. Progress in the application of these preventive and corrective approaches frequently involve legal, religious and social issues which determine, in many instances, the management approach taken. Resolution of these issues will need to consider the prospects in behavioral and educational research where research progress is contributing significantly to the correction and amelioration of the problems of life adaptation in existing retardates.

The National Institutes of Health efforts to prevent, cure, or ameliorate mental retardation emanate from at least five of the Institutes. Primary responsibility resides in the National Institute of Child Health and Human Development (NICHD), which recognizes the importance of this subject to such a degree that an entire branch, one of five in its extramural program, is devoted exclusively to development and support of mental retardation research and research training. The activities of three of the Institute's four other branches are also frequently of significance to the MR problem. Three branches of the Institute's intramural program have as their responsibility the conduct of mental retardation research. The Children's Diagnostic and Study Branch emphasizes research on problems of diagnosis and evaluation while the Behavioral Biology Branch and the Laboratory of Biomedical Science conduct research in the neurophysiological, electro-physiological, biochemical, metabolic and molecular aspects of mental retardation.

Other Institute's of the National Institutes of Health also contribute to the nation's research efforts to resolve the problem of mental retardation. Among these are the central nervous system research of the National Institute of Neurological Diseases and Stroke (NINDS), the National Institute of Allergy and Infectious Diseases (NIAID), the National Institute of Arthritis and Metabolic Diseases (NIAMD), all of which directly or indirectly extend the efforts of the Mental Retardation Branch of NICHD.

Some examples of the research supported by Institutes other than NICHD of importance to the solution of MR are the work on the effects of fetal and neonatal hypoxia on the developing central nervous system supported by NINDS; the NIAID supported work which has resulted in a preventive vaccine for rubella, a disease which often causes mental retardation in children whose mothers contracted it in the first trimester of pregnancy; and the NIAMD supported work on metabolic diseases, some of which result in mental retardation if they occur during fetal life or within a few months of birth.

The biological bases of mental retardation are many and varied. Aberrant intellectual development may result from hereditary causes such as inborn errors of metabolism (phenylketonuria is an example); meiotic or mitotic chromosomal abnormalities (mongolism or Down's syndrome, which may also be hereditary); endocrine dysfunction (cretinism); and severe protein or calorie deficiency during pregnancy or infancy may result in inadequate central nervous system development. It is also known that the conditions of poverty, lack of good perinatal care, chronic and debilitating diseases, poor sanitation, broken or inadequate homes, insufficient or non-existent medical care, and inadequate educational opportunity result in incidence and prevalence of mental retardation at rates 7 to 10 times higher than the average estimate of 3% for the population as a whole.

The National Institutes of Health encourages and supports research and research training in order to acquire basic information about the causes of mental retardation. Adequate knowledge of etiology will facilitate development of preventive techniques, which is the ultimate goal of these endeavors. Where primary prevention is not attainable, amelioration of human suffering and reducing the consequences of mental retardation to those affected, their families and society as a whole becomes a secondary goal. Using research grants for individual and program projects, research training grants to institutions of higher learning, fellowships and research career development awards to qualified individual scientists, and contracts to qualified institutions, the NIH is supporting a broad research effort in the biological, medical, clinical and behavioral sciences. The Mental Retardation Branch of the NICHD alone is supporting over 125 research and research training grants, awards and contracts in the various aspects of mental retardation. The estimated total outlay for support of mental retardation research and training by the NIH for FY 1970 approximates \$38 million.

I. Training of Personnel

A. National Institute of Child Health and Human Development (NICHD)

The need for more research workers in all fields and disciplines, with primary interest in mental retardation, remains critical. Research training grants which provide support for student stipends, faculty salaries, and necessary equipment and supplies for teaching and research are the primary mechanisms used for stimulating additional training. Seventeen mental retardation research training grants, totaling \$1,003,000, are being supported by NICHD in FY 1969. While substantial, this effort will still fall short of supplying the anticipated requirements for trained scientists. These training grants provide training in basic biomedical research, clinical research and behavioral research. In addition to trainees

directly involved in receiving stipends from these programs, a large number of other scholars also benefit from the existence of the specific programs through participation in seminars or courses and use of facilities established for or by the training program. Trainees range from Masters Degree candidates through post-doctoral trainees with up to 2 years residency already completed.

On an individual basis 8 research fellows are being supported with an additional 3 having been approved, but not yet activated by the applicants. This is a total of 11, up 2 from FY 1968. Research career development awards increased by 1 for a total of 5 in FY 1969. The fellowship awards cover basic biology, clinical medicine, and behavioral studies. The research career development awards are to 4 scientists working in basic biology and to 1 scientist studying discrimination and attention in learning.

B. National Institute of Neurological Diseases and Stroke (NINDS)

While the training program of the National Institute of Neurological Diseases and Stroke 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.

II. Research

A. National Institute of Child Health and Human Development (NICHD)

National Institutes of Health supported research covers nearly the whole spectrum of biological and clinical research disciplines and a great many of the behavioral ones as well. In recognition of the complexity of the disease entities involved efforts have been made to stimulate multifaceted and interdisciplinary attacks on the problem. The appropriate support mechanism for such research is the program project grant and some success is indicated by the increase in the number of such awards from 16 in FY 1968 to 21 in FY 1969. In all, 92 research grants (including program grants) and 4 contracts are currently active. Of these, approximately 70% of the research grants are in biomedical research and 30% in the behavioral research areas in terms of dollar amount. In contracts, 3 are biomedical and 1 is behavioral. In dollar amounts, 88% of contract expenditures go toward biomedical research and 12% toward behavioral research.

A large fraction of current biomedical research support is devoted to cytogenetic and tissue culture investigation of genetic defects including inborn errors of metabolism and mongolism. In the past year one investigator, supported by NICHD, has expanded and extended the knowledge gained from this research to the point where he (as well as others) is able to test cells and amniotic fluid obtained by

transabdominal amniocentesis at 14 weeks of pregnancy to determine whether the infant will be normal with respect to many of the diseases which can result in mental retardation. It is expected that, as this technique becomes refined and more easily employed, in utero management such as enzyme induction through surgical implantation, drug administration, and others will be developed. This technique, coupled with therapeutic abortion, where indicated, will result in a substantial reduction in the incidence of mental retardation.

The role of malnutrition in etiology of mental retardation is receiving increased attention by the NICHD. One investigator supported by NICHD has reported results of a longitudinal study which contains convincing evidence indicating that malnutrition occurring early in infancy can result in reduced intellectual capacity and ability to adapt to the environment. Additional studies have been mounted in this country and abroad and are currently receiving support from the Institute. Due to the difficulties of separating other environmental effects such as chronic infection, lack of social stimulation, etc., from those of malnutrition these studies are difficult to perform and their results must be interpreted with great caution. The available evidence from both animal and human studies dictates, however, that more knowledge be gained for a full understanding of the role of malnutrition in relation to intellectual development.

A contract for the investigation of the effects of improving the maternal diet during pregnancy has been let in a large urban poverty area in order to measure the effects of a more adequate maternal diet on the developing child. A study already in progress in a southern rural area to examine the effects of maternal dietary supplementation on offspring growth has been expanded this year to include measures of intellectual and behavioral development in the children. A study in Guatemala, supported jointly by NICHD and INCAP, has reached the stage of definitive data collection after a necessary long period of developing and testing methods and measurement scales of behavior. Preliminary data indicate that early severe protein-calorie deficiency results in deficits in behavior clustering in certain psychological areas. Similar research programs in Mexico and Chile are supported by the Institute.

Seven of the 12 mental retardation research centers authorized for construction under Part A, P.L. 88-164 were completed and operational in FY 1970. The completed centers are located at the University of Washington, Seattle, Washington; George Peabody College for Teachers, Nashville, Tennessee; Albert Einstein College of Medicine, Bronx, New York; University of California at Los Angeles, Los Angeles, California; University of Colorado Medical Center, Denver, Colorado; Cincinnati Children's Hospital, Cincinnati, Ohio; and, the University of Chicago, Chicago, Illinois. Centers at Children's Hospital Medical Center, Boston, Massachusetts; Fernald State School, Waltham, Massachusetts; University of Kansas, Lawrence, Kansas; and, the University of North Carolina, Chapel Hill, North Carolina are expected to be completed in FY 1971. The center at the University of Wisconsin, Madison, Wisconsin is scheduled for completion by July, 1972.

At the Federal level the NICHD has primary responsibility for assisting center administrations with the development and operation of the centers' programs of research and research training in the field of mental retardation and related aspects of human development. When fully operational it is anticipated that the centers will carry the major research thrust of our nation's efforts to combat mental retardation.

The research activities of the centers are many and varied. Several of the centers are working on the problem of mental retardation associated with depriving life circumstances. The center at Kansas is making notable progress in methods utilizing local people, especially mothers, in creating or improving the conditions under which the intellectual development of children is stimulated. Methods of constructive intervention to prevent or minimize poverty-linked retardation are under way and others are being planned at the Peabody Center. Studies with the same aims are under way or planned at the University of North Carolina where ways of preventing retardation in the disadvantaged through the use of psycho-social intervention are underway. The staff of the University of Wisconsin Center is currently deeply concerned with rehabilitative methods as well as biomedical research on metabolic disorders such as phenylketonuria. At the University of Washington Center the staff is planning an interdisciplinary, longitudinal research program to relate medical, biochemical, electrophysiological and other events during pregnancy with the neurological sequelae observed in infants and children. This will make possible elucidation of the role of events or processes occurring during gestation, birth and the neonatal period, which can result in mental retardation, and, hopefully, will assist in finding preventive or therapeutic measures.

B. National Institute of Neurological Diseases and Stroke (NINDS)

The National Institute of Neurological Diseases and Stroke sponsors research in mental retardation when mental retardation appears as a symptom, complication or sequela of some disease of the central nervous system. Consequently, a large number of research projects supported by NINDS can be said to be relevant to mental retardation research, although the interest of the scientist may be in the study of some particular phase of disease rather than in mental retardation directly. The research projects involved use nearly all of the scientific disciplines to some degree.

One of the Institute's major efforts which has great interest for mental retardation research is a collaborative project with 14 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 through the first year of school.

This program was started in 1959. The gathering of data has been completed for pregnancies, deliveries and on all children through the age of one year. About 30 percent of these children are now age seven, and are completing their examination schedule. Concurrent evaluations

indicate that about 77 percent of the eligible children have actually been examined at the age of seven. Of the remaining children, half of them have been lost to the study, but efforts are being made to find them.

These data are now being continually analyzed and reported. Two volumes of the collected bibliography of reports from this study: Volume I from 1963 through June 1969 and Volume 2 from July 1968 through June 1969 have been published. These are available from the Perinatal Research Branch, NINDS, Wiscon Building, Room 708, Bethesda, Md. 20014.

Research into inborn metabolic errors is being supported in order to discover how early these diseases 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. The biochemistry of these diseases and the relationship of the biochemical activities to brain function are being studied. These studies, which are directly relevant to the development of mental retardation, are identifying the enzyme defects which are specific for the various diseases. Research is beginning to see if substitution therapy can be developed.

Studies are underway to attempt to link the pathological patterns of brain damage to functional development. In this area the Collaborative Study will be valuable in providing both normative data and incidence statistics relative to mental retardation.

The early diagnosis of mental retardation is frequently extremely difficult. 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 often follows hydrocephalus and brain tumors in childhood. Development of appropriate surgical or pharmacological therapy remains an objective of the Institute. The Institute is also supporting programs which investigate the mechanisms involved in meningitis or meningoencephalopathy to determine proper preventive and therapeutic approaches.

OFFICE OF EDUCATION

Introduction

Programs dealing with handicapped children in the Office of Education have been placed under the administrative direction of the Bureau of Education for the Handicapped. This is consistent with the efforts of the Office of Education to provide maximum educational programming for all children. The Bureau is responsible for supervising and implementing current and new legislative authorities to provide funds for projects and programs relating to the education, training and research of handicapped children and youth. These children include those who are mentally retarded as well as those who are hard of hearing, deaf, speech impaired, visually handicapped, seriously emotionally disturbed, crippled, or other health impaired and require special education.

The Bureau is specifically charged with the task of helping each handicapped child develop to the maximum those skills and talents which will enable him to become independent and self-sufficient as an adult. The Bureau, through its various support mechanisms, directs programs designed to (1) increase the number of qualified professional personnel (2) improve educational services in local and State programs; (3) stimulate acquisition, evaluation, and utilization of modern educational equipment, media, and teaching materials; and (4) encourage theoretical and applied research, the use of successfully tested research, and advanced educational techniques.

The impetus for change and its challenge is part of the climate of the Bureau. It is reflected in the mood and feeling of its professional staff in their drive for commitment and awareness to innovate, to initiate, to lead, to evaluate, and "to be first" to enter new areas to benefit the handicapped. The Bureau provides leadership at every level to provide resources, knowledge, and awareness not limited by lack of perception, or vision, or by lack of dedication to the handicapped by those responsible for effecting policy. Further, it maintains a constant and close contact with its constituents via conferences, institutes, professional meetings, and the National Advisory Committee on Handicapped. The latter Committee is responsible for reviewing the administration of the Bureau, its programs, and the status of legislation in connection with the use of Federal funds to assist State education agencies, institutions of higher education, and other non-profit agencies that administer Federal programs involving the education of handicapped children. Throughout its activities, the Bureau's stress is on cooperation and open communication with all agencies serving the handicapped for no program effort can be truly effective in isolation.

In its continuing efforts to improve the educational opportunities for all mentally retarded children, the Bureau jointly sponsored and supported with the President's Committee on Mental Retardation a conference on "Problems of Education of Children in the Inner City." This conference was held August 10-12 at the Airlie House in Warrenton, Virginia and brought together approximately one hundred persons concerned with programs for the mentally retarded and other children

in the inner city. Public school teachers, administrators, parents, psychologists, sociologists, teacher aides, university personnel, and Federal officials were equally distributed among the conferees.

A full report of the above conference, its findings, and its recommendations may be obtained early in 1970 from the President's Committee on Mental Retardation.

Through the Bureau's Office of Program Planning and Evaluation, long-range plans for program implementation and support have been developed. These plans will insure greater coordination and integration of the various Bureau programs as well as facilitate maximum programming for all handicapped children. This same office has instituted a number of evaluation studies which will assess thoroughly the effectiveness of funding patterns, research and demonstration programs, personnel training models, dissemination projects, and distribution of services to handicapped children. The findings of these studies will be analyzed and then utilized to improve all program efforts of the Bureau.

A sound Federal program must plan and accurately assess the effectiveness of its planning. It must adapt to an evolving educational system and maintain responsiveness to the needs of handicapped children. New models must consistently be developed, implemented, and evaluated if positive advances are to be realized. The Bureau's Office of Program Planning and Evaluation provides these vital ingredients in a most exemplary manner.

In order to efficiently implement its assigned responsibilities the Bureau is administratively organized into three major divisions and an Office of the Associate Commissioner which includes a Program Planning and Evaluation Office; an Information and Reports Office; an Executive Office; and an Office of Program Implementation. This latter office is responsible for developing guidelines to effectively implement new legislation which expands and creates educational opportunities for handicapped children. In 1969, this office successfully initiated the first Federally supported early education programs for the handicapped as authorized by the Handicapped Children's Early Education Assistance Act of 1968, Public Law 90-538.

Each of the three divisions provide an important element in the functions rendered by the Bureau in making up a total program of service, training, and research for the mentally retarded as well as other handicaps of children. The following pages describe these services for mentally retarded children on a divisional basis.

I. Division of Training

A. Purpose

The Division of Training Programs initiates, maintains, and improves programs for the preparation of professional leadership and teaching personnel to educate handicapped children. Divisional programs which are designed to implement this purpose are two-fold in their attack, in that they must provide: (1) classroom supervisory, consultative, and administrative personnel for State and local special education programs;

and (2) personnel for higher education institutions responsible for preparing administrative and classroom personnel. The Division of Training Programs in an effort to effectively implement training programs for the mentally retarded has organized a Mental Retardation Branch. This Branch, one of three in the Division, is responsible for the coordination and administration of all programs in the area of mental retardation.

B. Need

As more States legislate mandatory education for handicapped children the major problem faced in implementing such legislation is an acute shortage of qualified personnel. According to data received from the State Plans submitted by State education agencies under Title VI, ESEA, for fiscal year 1968, approximately 376,000 teachers and other personnel were needed to provide educational services to all handicapped children then identified. Approximately 100,000 or 26% of the preceding personnel needed were in the area of mental retardation. Still, only 47,000 or 47% of the latter number needed for the education of the mentally retarded were employed in 1968, and many of these persons lacked full certification. If general turnover rates applicable to the education profession are applied, approximately 10% of the special education teachers will leave the field each year. At current rates of preparing professional personnel in mental retardation more than twenty years will be needed to close the gap between supply and demand, if all other variables remain constant.

As a result of the teacher shortage, approximately two-thirds of the more than five million handicapped children of school age are not receiving special educational services they require. Many of the established programs are actually of minimal quality, because they have been started with less than fully qualified personnel. This current deficit, as in the past, not only retards the systematic growth of special education, but simultaneously requires the majority of our nation's handicapped children to accept an education program inappropriate to their needs. Similarly, college and university personnel too essential to the preparation of teachers are also in short supply. For academic year 1969-70, approximately 200 new faculty members were needed; however, less than one half of this number was available.

C. History

In 1958, Public Law 85-926 was passed by Congress authorizing an appropriation of \$1 million per year for the preparation of professional personnel in the education of the mentally retarded. This initial piece of legislation was directed at preparing college and university personnel to staff the then existing programs, and much needed new programs for preparing personnel to work with the handicapped in State and local school systems. Between academic years 1959-60 and 1963-64, 692 graduate fellowships were granted to 484 individuals. The majority of these individuals became college and university professors while others became State and local special education leadership personnel. In fact, a recent survey made of the above fellowship recipients indicated that approximately 75% of all programs in mental retardation at colleges and universities are directed or coordinated by these individuals.

On October 31, 1963, P.L. 88-164 was signed into law. Section 301 of this Act amended P.L. 85-926 to: (1) expand the program to include not just the area of mental retardation, 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; (3) extension downward into the senior year undergraduate levels; and (4) increase the monies authorized for these purposes. Since P.L. 85-926 was passed in 1958, approximately 23,000 fellowships and traineeships have been awarded to individuals preparing to work with mentally handicapped children. This includes both short-term and full academic year awards.

A study conducted in February of 1964, of 245 former P.L. 85-926 fellowship recipients revealed that over 90 percent of them were engaged in the field of special education, including the mentally retarded, and about 70 percent were engaged primarily in the field of mental retardation. Sixty-eight of the 245 former fellows indicated that they were currently employed by a college or university, 80 were employed in an administrative or supervisory capacity (19 of these were employed by State educational agencies), and 54 returned to the classroom as teachers of the mentally retarded.

Public Law 85-926 was further amended with the passage of Public Law 89-105 and 90-170. These amendments expanded and extended the program through fiscal year 1970, authorizing appropriations of \$29.5 million for fiscal year 1967; \$34 million for fiscal year 1968; \$37.5 million for fiscal year 1969; and \$55 million for fiscal year 1970. These funds have been, and will be, used as stipends for students as well as to support colleges, universities, and State education agencies with the cost of instruction.

Table I - Awards made in the area of mental retardation since the passage of P.L. 85-926 (Fiscal Years 1960 through 1969)

Fiscal Year	Number of Traineeships & Fellowships	Number of Higher Education Institutions Participating	Number of State Education Agencies Participating	Total Amount Obligated
1960	177	16	23	\$ 985,222
1961	164	18	41	993,433
1962	160	20	46	997,000
1963	163	19	48	996,433
1964	2,357	108	50	6,419,332
1965	2,506	153	50	6,569,815
1966	3,110	162	52	7,658,002
1967	3,816	177	53	8,891,072
1968	4,521	177	53	8,493,668
1969	6,366	193	53	9,382,084
1970**				

**Appropriations will be approximately equivalent to fiscal year 1969 (awards not available at time of this report)

The number of individuals being trained in mental retardation under this grant program is significant. The improvement and expansion of the many teacher-training programs in mental retardation throughout the Nation--resulting directly and indirectly from the grant program -- will, in the long-run, be of even greater significance. Evidence suggests that the support grants which accompany traineeships and fellowships have enabled a great many of the currently participating colleges and universities to add staff, expand the course offerings, and better supervise the observation and student teaching experiences of the students. The total number of students benefiting from these program improvements at the various colleges and universities will, in most instances, far exceed the number of students who are on a fellowship or traineeship.

It is readily apparent that the "old" P.L. 85-926 program, and its major amendment, P.L. 88-164, has enabled a great number of colleges and universities to develop and/or expand their teacher-training programs in mental retardation. A current analysis of the more than 220 institutions requesting funds in the area of mental retardation indicates that more than 150 of them have on their faculties former fellows who review training under Public Law 85-926.

It will be a number of years before there will be a great reduction in the gap between the number of trained teachers and "leadership personnel" in the area of mental retardation who are needed and the number who are available. However, Public Law 85-926 -- prior to and since the amendments by Section 301 of Public Law 88-164 -- has provided the necessary beginning in the effort to close this gap.

D. Related Program Activities

1. Training of Physical Educators and Recreation Personnel

In addition to the amendments of P.L. 85-926 cited earlier, P.L. 90-170, Title V established a program entitled "Training of Physical Educators and Recreation Personnel for Mentally Retarded and Other Handicapped Children." Section 501 of this bill authorized appropriations of \$1 million for fiscal year 1968, \$2 million for fiscal year 1969 and \$3 million for fiscal year 1970.

In fiscal year 1969, the Bureau of Education for the Handicapped through the Division of Training Programs awarded a total of \$300,000 to fifteen universities and colleges to assist in providing professional training in physical education and recreation for the handicapped. Funds were provided to thirteen institutions to assist them in developing a specialized prototype training program for undergraduate and/or graduate students. Two schools were awarded funds to support short term summer workshops for the purpose of stimulating and upgrading programming for the handicapped child.

Appropriations will be approximately equivalent to fiscal year 1969. Fifty seven applications for Fiscal Year 1970 funds to assist in program development, prototype programs and short courses were received. However, awards had not been made prior to the submission of this report.

2. Program Development Conference

A conference was sponsored during the month of September 1969 by the Division of Training Programs for special educators from institutions of higher education which received program development grants for fiscal year 1969 (academic year 1969-70). Six institutions with developing programs in mental retardation participated. During the conference representatives of these institutions responsible for implementing new teacher preparation programs in mental retardation shared mutual experiences and various problems faced in their program development activities. The sharing of ideas by program development grant directors in mental retardation with directors in other areas of the handicapped was found to be extremely valuable to all in attendance. This conference like its predecessors, has served to lessen the mortality rate of program development grants to less than 3% of all programs so funded in the area of mental retardation.

A similar conference is planned for the spring of 1970, for recipients of program development grants for fiscal year 1970.

E. Cooperative Activities

The Division of Training Programs in an effort to utilize all resources in the provision of quality educational programs for all retarded children has entered into cooperative funding or working arrangements with other personnel training programs in the Office of Education and the Social and Rehabilitation Service. The following are three examples of the Division's cooperative efforts:

1. University Affiliated Facility Program

The Division of Training Programs in cooperation with the Division of Mental Retardation of the Social and Rehabilitation Service provided support monies to special education components in sixteen university affiliated facility programs for fiscal year 1969. The extent of the Division's support ranged from approximately \$20,000 to \$30,000 with a total expenditure of \$390,747 for the sixteen supported facilities.

The Division supports a special educator on the university affiliated facility core faculty. The special educator is responsible for instructing medical students, psychologists, social workers, and other related medical personnel as well as students majoring in special education. He serves to effectively integrate special education concepts into the overall interdisciplinary training program of the university affiliated facility.

The universities receiving support through this program for fiscal year 1969 were; Georgetown University; University of California at Los Angeles; John Hopkins University; University of Indiana; Miami University (Florida); Ohio State University; University of Cincinnati; University of Tennessee (Memphis); Children's Hospital (Harvard); University of Oregon; University of North Carolina; University of Alabama (Birmingham); Utah State University; University of Wisconsin; Georgia Retardation Center (Georgia Department of Public Health; and the University of Kansas.

2. Teacher Corps

The Teacher Corps and the Division of Training Programs are jointly supporting a teacher corps program at the State College of Arkansas in Conway, Arkansas. Specifically, the Division provides funds for the support of one teacher corps team (six master's level teachers) who receive instruction in special education of the mentally retarded. Concurrent with their instruction, the teacher corps team members will be working in public school systems with rural disadvantaged children throughout the State of Arkansas.

3. Bureau of Educational Personnel Development (Education Professions Development Act - P.L. 90-35)

The Bureau of Educational Personnel Development and the Bureau of Education for the Handicapped have agreed to cooperate in the funding of programs which provide special education training to regular educational personnel who are working with handicapped children. Approximately 15 percent of the funds available under Part C and D of the above Act will be used in programs to train regular educational personnel such as counselors, educational technology specialists, teachers, and administrators who have an interest or need to become more knowledgeable regarding the problems of the handicapped.

The major responsibility for fulfilling this commitment rests with the Special Education Training Branch in the Division of School Programs. Priority is placed on projects for training decision-makers and change agents such as school administrators, supervisors, teachers of teachers, and State education agency personnel, who may influence the behavior of regular classroom personnel in dealing with the individual learning and behavior problems of handicapped children. Emphasis is placed on the prevention of severe learning problems, particularly for disadvantaged children. In fiscal year 1969, the Special Education Training Program supported 80 projects in 34 States for the training of 5,500 persons, many of whom were for personnel dealing with mentally retarded children. Colleges and universities conducted 58 of these projects, 16 were conducted by local school districts, and six by State education agencies. A Special feature of the program is the Special Education Leadership Training Institute, which trains project directors, assists in the development of new projects, and evaluates the entire program by evaluating selected projects.

In addition, other BEPD programs do support some projects which involve the training of educational personnel to deal more effectively with the problems of handicapped children. These include the Early Childhood Program, Educational Administration Program, Career Opportunities Program, Vocational-Technical Education Program, and the State Grants Program to meet immediate critical shortages of teachers and teacher aides.

When one considers an earlier statement made in this publication to the effect that approximately two thirds of all handicapped children are not receiving specialized educational intervention, it becomes quite obvious that this cooperative agreement will have great impact on improving services for the handicapped. The program, when fully implemented will facilitate greater cooperative interactions between regular and special educators. This will ultimately lead the way to maximum educational programs for all handicapped children.

F. New Programs

1. Special Projects

Training programs to be truly effective must reflect the growth and evolution of special education programs brought about through expansion of research and service activities. As a result training programs must be flexible and enable a continual, but systematic modification of their approaches. Proven traditional approaches to training should be retained, but every opportunity to blend the old approaches with new directions as increased knowledge and experience becomes available, should be encouraged.

To provide a means for developing new models the Division of Training Programs has implemented a Special Projects Grant Award Program. The purpose of this program is to plan; to test new models of training; and to evaluate the effectiveness and efficiency of these new models in preparing personnel to work with handicapped children. These grants are designed to provide the wherewithal for the field of special education to develop, implement, and test new approaches for the preparation of personnel to meet current and projected needs in the education of handicapped children.

There are two types of grants within the special projects award program: planning and prototype (including evaluation). Planning grants will be utilized to provide funds for the support of personnel, travel, and other costs necessary for developing a detailed plan for implementation of a prototype.

Prototype grants will be utilized to implement and test new training approaches. Successfully implemented prototype grants which provide viable approaches to training will be placed into the regular award program for future funding to other training agencies in the United States.

Twenty special project grants were awarded for fiscal year 1969, in amounts ranging from \$4,348 to \$142,797. Universities participating in this program were: American University; George Peabody College; University of Illinois; University of Minnesota; Southern Connecticut State College; University of Iowa; University of Kansas; Utah State University; Syracuse University; Boston University; University of Massachusetts; Georgia State College; Colorado State College; University of Washington; University of Hawaii; San Francisco State; Virginia Commonwealth University; University of Oregon; University of Texas; and Rutgers University.

F. Future Goals

The goals of the Division of Training Programs are to:

1. Develop "quality" personnel preparation programs at all levels -- undergraduate through graduate.
2. Provide greater opportunities for the interaction of Division staff with university personnel regarding issues in the training of professional personnel.
3. Establish a clear and well defined "State of the Art."
4. Continue cooperating with State Departments of Education to effect comprehensive planning for the training of personnel in special education.
5. Provide continued leadership to the developing university affiliated programs to insure the incorporation of strong special education components into each program.
6. Produce informative materials concerning the education of mentally retarded children and the training of professional personnel to work with them in educational and related placements.
7. Develop realistic new training programs for personnel at preschool and work-study levels.
8. Effectuate qualitative evaluation of all current programs preparing personnel in mental retardation.

II. Division of Educational Services

A. Purpose

The Division of Educational Services provides direct support to handicapped children through services at the classroom and intermediate levels. The Division offers support to State, regional, and local programs to assist in developing and maintaining leadership in the education of handicapped children.

B. Historical Development

Public Law 85-905, the Captioned Films for the Deaf Law, was passed by Congress in 1958 to provide entertainment films for the deaf. This law has subsequently been amended by P.L. 87-715 in 1962 and P.L. 89-258 in 1965 to allow for training, research, production and distribution of educational material for use by deaf children. In December 1967, this authority was again expanded to include educational services to all categories of handicapped children through the 1967 amendments to the Elementary and Secondary Education Act.

Public Law 89-313 was passed by Congress in November 1965, which extended the benefits of Title I of the Elementary and Secondary Education Act to handicapped children in State-supported programs.

During recent years, as local facilities for the handicapped have increased, State schools have found the composition of their resident populations changing from the mildly handicapped to large percentages of children who are severely mentally retarded, and those who have serious handicaps in addition to mental retardation. Model and pilot programs for these types of children have been conducted under P.L. 89-313 in many States.

These funds have enabled institutions and agencies to develop programs for children who have not previously been considered capable of responding to educational or rehabilitative services. The results in many instances have been encouraging and special educators and staff in residential institutions have raised their levels of expectations for such children. While this program has had a relatively limited funding based upon its authorization, significant results have been realized especially in terms of planning for comprehensive services. Monies allotted under P.L. 89-313 for handicapped children were \$15,065 million for fiscal year 1967, and \$24,747 million for fiscal year 1968, and \$29.7 million for fiscal year 1969. In fiscal year 1968, 60,276 mentally retarded youngsters were assisted under this program at an expenditure of \$11,118,338.

The 1966 amendments to the Elementary and Secondary Education Act provided under Title VI-A, a program of support to local education agencies through a State plan program. While this law authorized \$150.0 million for fiscal year 1968, the appropriations were only \$14.25 million. For fiscal year 1968, \$162.5 million was authorized and \$29.25 million was appropriated.

The 1968 amendments to Title III of the Elementary and Secondary Education Act, provide that 15% of the funds for fiscal year 1969 be spent for innovative and exemplary projects for handicapped children.

It is estimated that \$24,715,328 of the funds under this Title will be expended for services to the handicapped during fiscal year 1970.

P.L. 90-247 provides for the development of regional centers for deaf-blind children under Title VI-C. The appropriation for 1969 was \$1 million which was used for both development of programs and for direct services to deaf-blind children and their parents. The law permits use of these funds for deaf-blind children with additional handicaps, including those who are mentally retarded.

The Handicapped Children's Early Education Assistance Act, embodied in P.L. 90-538, provides for establishment of a number of model programs for serving very young children with various handicaps. These programs will be distributed strategically throughout the country to serve as models for the development of future preschool and early childhood programs. The 1969 appropriation was \$1 million, which served as planning and development funds during the first year of the program and provided for the support of twenty-one planning and three operational centers.

C. Impact on Mental Retardation

Programs will have a significant and far-reaching impact upon education and rehabilitation of mentally retarded individuals. Through such direct support programs Title VI (aid to local programs), P.L. 89-313 (aid to State programs), more extensive and comprehensive programs will develop which will include the utilization of the latest teaching techniques and educational technology. Media Services and Captioned Films for the Deaf with expanded responsibility should provide for an opportunity for State and local programs to take advantage of educational materials, media, and equipment especially designed to meet the needs of the handicapped. Certainly the newly established interest in early education programs for the handicapped will have major impact on mental retardation. This is especially so in the case of those youngsters from culturally disadvantaged areas who greatly need early stimulation. Without such stimulation, it is highly probable that many of those youngsters might become special education candidates.

D. Current Activities

During 1968, the Division of Educational Services held five Regional Conferences to acquaint Title I (89-313) Title VI-A and Title III Coordinators with exemplary projects for the handicapped. The Division staff met with over 600 professional and interested parties to discuss the over-all service program of the Bureau at these conferences.

During fiscal year 1969, the total funds available for services to handicapped children from this Division exceeded \$88 million. Most of this money was made available through State Plan programs. Under the State Plan programs, it is estimated that 25 to 30 percent of the funds will be expended for retarded children.

These programs have led to an interest in comprehensive planning. The Division plans to work with State and project personnel to develop

long-range plans and evaluation procedures during 1969. These activities are serving the special educational and related needs of retarded children through such programs as pre-school, elementary, and secondary education projects which may include: curriculum enrichment, expansion, improvement; summer school programs; preschool and school readiness programs; physical education and recreation; prevocational and vocational training; inservice training of teachers; and improved diagnostic services.

E. Future Goals

The goals of the Division of Educational Services are to:

1. Provide significant support monies to both State-supported and local educational programs to assure quality education for all handicapped children.
2. Provide intermediate services such as comprehensive educational diagnostic resource centers on a regional base to provide services for handicapped children and their families. In addition to direct services to children, these centers will provide consultative services to State and local educational agencies to assure the latest available information from research with respect to the learning process.
3. Provide wherever needed comprehensive regional programs for severely multiply handicapped children such as deaf-blind children.
4. Provide through media services the research, production, and distribution of specially designed materials and programs for educational technology for handicapped children. To provide training in the use of media for teachers of the handicapped.
5. Provide through Instructional Material Centers educational management and information systems.

III. Division of Research

A. Purpose

The Division of Research promotes and supports research and related activities which show promise of leading to improvement in educational programs for handicapped children. Support is available for research, dissemination, demonstration, curriculum, and media activities, and for support of Regional Resource Centers.

B. History

The program now administered by the Division of Research was initiated during Fiscal Year 1964 with an appropriation of \$1 million authorized under Title III, Section 302 of Public Law 88-164. The scope and flexibility of the program have been extended through amendments to this basic authorizing legislation in Public Law 89-105, Public Law 90-170, and Public Law 90-247. Table 1 provides data on the authorizations, appropriations, obligations, and number of projects supported under this program.

C. Impact on the Problem of Mental Retardation

It is difficult to assess the direct impact of research activities since the lag between the discovery of new knowledge and consequent changes in educational practices obscures the picture. However, some information on the impact of the program is available. As of the end of Fiscal Year 1968 approximately sixty final reports of research monitored by the Division of Research had been made available to practitioners in the field. Many of these research projects have also resulted in other publications in the professional literature. Although the systematic collection of data on the actual implementation of research findings from these projects is just beginning, there are many instances in which these findings have had a direct impact on programs for the mentally retarded.

D. Future Goals

The history of research on handicapped children suggests that minimal gains are obtained by spreading research monies too thinly. Many of the most important problems in education require a massive effort if solutions are to be found in time to help today's children. The Division of Research proposes to support the establishment of Research and Development Centers to focus on the more difficult problems of evaluation, communication, instructional procedures, etc. Through the combined efforts of Research and Development Centers and programmatic research, definite improvement in instructional procedures may well be realized within the next several years.

At the same time, systems of dissemination will be evolved which will facilitate the acceptance of these new models by local school administrators. The new systems of dissemination will be built upon the foundation already developed by the Instructional Materials Centers and a system of Regional Resource Centers currently being developed.

As more funds for research become available, engineering technology will more and more become a part of research supported by this Division. This development has been made possible by the amendment permitting the use of contracts as well as grants for research and development activities. Engineering technology, programmed instruction, and the "systems approach" to education will occupy a major place in the Division's activities in the years to come.

E. Current Activities

The Division currently supports a wide range of activities relating to the education of mentally retarded children. One of the most visible of these is the network of Instructional Materials Centers for handicapped children. Although serving teachers of all the handicapped, these centers have a major commitment to mental retardation. The Instructional Materials Centers, 14 in all, are scattered across the country to serve specified regions. The primary objective of each center is to keep teachers of handicapped children aware of new developments in educational materials. The centers are evaluating existing materials as to their relevance to the handicapped and assisting

in the development of new materials. Since the 14 centers are connected as a network, any information located in one center is immediately available to all other centers.

The Comprehensive Research and Demonstration Center for Handicapped Children, now under construction at Teachers College, Columbia University, similarly has a major emphasis on the problems of the retarded, although at the same time relating to the educational problems of many categories of handicapped children. This center represents a major investment of research funds, both for construction and operation, in an attempt to develop an intense effort in this area of education. Under the Regional Resource Center program, each center would provide a bank of advice and technical services upon which educators in a region could draw in order to improve the education of handicapped children. The primary task of a Center would be to focus on the special education problems of individual handicapped children referred to it. Each Center would provide testing and educational evaluation of the child, and in the light of this evaluation would develop a program of education to meet the child's particular requirements. Working closely with the handicapped child's parents and teachers, each Center would then assist the school (or other appropriate agency) in providing this program, periodically reexamining and reevaluating the program, and making any adjustments which are necessary to keep the program responsive to the educational needs of the handicapped child. Four Regional Resource Centers were funded in FY 1969. These centers are located in Eugene, Oregon; Las Cruces, New Mexico; New York, New York; and Des Moines, Iowa.

Other research activities now under way are attacking problems of teaching and learning with the mentally retarded. One such project has suggested that time spent in learning to learn can make a significant difference in the performance of retarded children. Other projects are developing and testing new curricula for the retarded.

Table 1

Division of Research - - - Historical Data

Year	Authorization	Appropriation	Obligations	#Projects
1964	2,000,000	1,000,000	999,739	34
1965	2,000,000	2,000,000	2,000,000	53
1966	6,000,000	6,000,000	5,994,231	133
1967	9,000,000	8,100,000	8,049,041	127
1968	19,500,000	11,100,000	10,794,113	135
1969	21,750,000	13,600,000	13,593,786	160
1970	28,000,000	----	----	----

IV. Other Office of Education Programs
for the Mentally Retarded

The Cooperative Research Act (P.L. 89-10, Title IV) supports several projects concerned with mental retardation. Some of the activities funded under this program have focused upon the development of a project enabling educable mentally retarded children to receive vocational training in food service; the relationship between the training experience and certain personality characteristics of teachers and the progress made by trainable mentally retarded students under their care; and comparisons of learning and retention techniques with mentally retarded children.

The Vocational Education Amendments of 1968 provide that at least 10 percent of each State's allotment for basic grants must be used for programs for persons who are handicapped, including persons who are mentally retarded or seriously emotionally disturbed. This provision of the Act becomes effective in fiscal year 1970. It is anticipated that about 50,000 mentally retarded persons will be served with about \$11,500,000.

SOCIAL AND REHABILITATION SERVICE

Introduction

The Social and Rehabilitation Service (SRS) was established August 15, 1967, by the Secretary of Health, Education, and Welfare to join under a single leadership the Department's income support programs for needy Americans and the social and rehabilitation programs that many families and individuals need.

The organization is designed to provide a stronger emphasis on rehabilitation in social and welfare programs.

In October of 1969 a Departmental reorganization shifted the Child Welfare Services of the former Children's Bureau to the newly established Community Services Administration. In addition, the Maternal and Child Health Activities were transferred to the Health Services and Mental Health Administration.

The five major components of the agency are: the Administration on Aging; Assistance Payments Administration; Community Services Administration; Medical Services Administration; and the Rehabilitation Services Administration.

All of these component administrations have major responsibilities in the area of mental retardation. The reorganization has placed new responsibility for the mentally retarded on the Administration on Aging, the Rehabilitation Services Administration, and the Community Services Administration. The latter unit is now concerned with the provision of social and rehabilitative services to various categories of public assistance recipients. The Assistance Payments Administration contributes substantially through financial and medical assistance to mentally retarded individuals who qualify for the various public assistance programs. The Rehabilitation Services Administration also includes the Division of Mental Retardation.

Also located in SRS is the Office of Research, Demonstrations and Training. This office administers a program of grants to States and to public and private, nonprofit agencies to pay part of the cost for research, demonstrations, and the establishment of special facilities and services contributing to the field of rehabilitation.

New legislation has reaffirmed and expanded the Nation's commitment to programs on behalf of the mentally retarded. This includes the Mental Retardation Amendments of 1967, the Vocational Rehabilitation Amendments of 1965, 1967 and 1968, and various aspects of the Social Security Amendments of 1967.

The responsibilities and activities of the component agencies of the Social and Rehabilitation Service and the provisions of the new legislation with respect to programs for the mentally retarded are described on pages 42 to 65.

Office of Research, Demonstration and Training

1. Rehabilitation Research Branch Program of the Research and Demonstration Grants Division

This Branch carries on a substantial program of research on problems of rehabilitation of retardates. Areas covered include evaluation of aptitudes and abilities, analysis of jobs which the retarded can perform, opening of new occupational areas for the retarded, improvement of counseling techniques, development of new methods of training and job adjustment and evaluation of facilities and programs to assist the transition of the retardate from the institution or other sheltered environment to community participation. The 1965 Amendments to the Vocational Rehabilitation Act recognized in particular the needs of retardates by providing up to eighteen months of services during which the individual is evaluated for employment potential. These amendments also recognized the need for continuing care and study in the form of provision for improved workshops for retardates and other handicapped persons.

The Amendments of 1968 have focused attention on the necessity for research on retardation as a function of cultural deprivation. Current programs of research and demonstration are, therefore, increasingly concerned with new approaches to retardation in ghetto areas, and especially model city neighborhoods. Rehabilitation techniques already developed through research are being extended to problems of the hard core welfare client.

Emphasis is placed on the coordination and focusing of all relevant community agencies on the problems of the retarded. Projects in five different cities have demonstrated ways of most fruitfully bringing together the services of agencies involved in programs for the retarded. An additional study evaluated the efforts of one of these coordinated services programs.

Culture-fair assessment of rehabilitation clients has become of increasing importance as selection for jobs has extended to cultural handicaps. A simple pictorial inventory which will assist in solving this problem for retardates is the recently completed Vocational Interest and Sophistication Assessment Test standardized on 3,000 retarded persons and predicting what job an individual will find most satisfying to him in terms of his interests.

A variety of community based projects demonstrating involvement of community resources for training of retarded and for their transition to the wider community are the results of recent research efforts. For example, a substantial number of work study programs for retarded adolescents have been sponsored by State Divisions of Vocational Rehabilitation jointly with local school boards, parent organizations, private schools, and State departments of education. These projects were based on prototypes developed in the vocational rehabilitation research and demonstration program.

The Bourbon County Schools work-study project, one of several in Appalachia, was established in Kentucky, a State with one of the highest dropout rates in the nation. The retarded subjects were children of impoverished parents; the majority were from homes of tenant or farm laborers with earnings well below poverty level. Despite the massive handicaps of cultural deprivation and mental retardation among the youngsters studied, this project, over its three-year term, reported a dropout rate of only 5 percent. Moreover, 88 percent of the sample of youngsters served have been trained and placed in jobs thus contributing not only to their own independence, but also to the economic welfare of their parents and the community at large.

During the past three years, the State Divisions of Vocational Rehabilitation have conducted energetic programs to place the retarded in a wide variety of civil service jobs. The District of Columbia, DVR and George Washington University have completed a follow-up study of the first 2,000 mentally retarded workers placed with the Federal government throughout the country to determine how effective the program has been and how to improve and expand it to State governments as well.

In order to accelerate training and make it more widely available, the research program has supported a number of projects demonstrating automated teaching techniques for the retarded. One of these, a research demonstration completed last year by the Devereux Foundation, Devon, Pennsylvania, found that automated teaching methods combined with regular classroom work proved more effective than machine methods along or classroom instruction alone in enabling retarded students to utilize learned material in a practical work situation.

The most significant recent research and demonstration development for the retarded is a set of six projects to be carried out jointly by the National Urban League, Family Services Association of America and the National Association for Retarded Children. These are demonstrating in model city neighborhoods new and more effective ways to reach culturally deprived and disadvantaged families with essential services for members of the families who may be retarded.

2. Rehabilitation Research and Training Centers Program

The Research and Training Centers Division of the Office of Research, Demonstrations, and Training has responsibility for administering 19 Rehabilitation Research and Training Centers for mental retardation 8 of which are in distinct organizational and physical entities providing a continuing framework for psychological, social, vocational and rehabilitation research and training, and at least on a demonstration basis, a comprehensive program of evaluation, training, counseling and placement of the mentally retarded individual. The three Mental Retardation Research and Training Centers currently sponsored by the Social and Rehabilitation Service of the Department of Health, Education, and Welfare, are the University of Wisconsin, the University of Texas, and the University of Oregon.

The research conducted by these centers encompasses many aspects of the rehabilitation process, from onset to training and placement of the retarded individual. It is broadly directed to a wide range of

psychosocial, vocational, or other fields of rehabilitation, and also to specific problems in the many aspects of rehabilitation of the retarded.

The training program of these centers provides training of all types, long-term as well as short-term, professional, technical, and for all categories of students, graduate or undergraduate, working in the medical, health-related or other professions engaged in rehabilitation. The program provides training in such areas as the principles of rehabilitation of the retarded and the special problems related to individual or groups of educational, psychosocial, vocational, and medical and other disciplines in the practice of rehabilitation. In all instances, training has been based upon a defined, organized program of instruction designed for undergraduate and graduate students, interns, and professional workers in the field of rehabilitation. Selected sub-professional workers have also been trained.

In 1969, the three Mental Retardation Centers conducted 101 research projects. They are continuing to seek out the cause of retardation, to assess the potential for education and rehabilitation, to develop training and remedial programs suited to the needs of the retarded, and to ascertain the actual learning and socialization difficulties encountered by the retarded. Also being emphasized is the development of adequate motivation for work in the retarded through family, school, and community resources.

The Mental Retardation Research and Training Centers are directing attention to, and advancing understanding of, behavior modification techniques in a variety of settings, the learning and socialization processes, psycho-social testing, work adjustment and vocational rehabilitation procedures. Such studies will hopefully bring about new knowledge not previously available, to be utilized in preparing the retarded for productive, independent living. This research will also be helpful in planning and developing remedial and rehabilitation programs for the disadvantaged and culturally deprived in becoming more self-sufficient.

As an example, the University of Wisconsin Research and Training Center in Mental Retardation (RT-11) has initiated a study on the major personality factors which characterize the adolescent retardate residing in the community. These adjustment characteristics have a significant effect on vocational success and hence, the data obtained from this study will make possible a determination of the effectiveness of behavior modification and other reinforcement techniques.

In the area of training, 30 short-term courses attended by 2,094 trainees were sponsored by the three Mental Retardation Research and Training Centers. These included training for rehabilitation counselors, physicians, special education personnel, nurses, parents, attendants, and others in specific rehabilitation techniques leading to employment of the retarded.

As an example, the University of Texas (RT-12) and the University of Wisconsin (RT-11) Research and Training Centers provided training to over 200 volunteers in the community during 1969. The University of Wisconsin provided training to older inner-city women to work with the retarded in Center project activities and other community service

organizations. The University of Texas provided short-term workshops for volunteers from local mental retardation interest groups to organize and develop needed community service programs.

The Rehabilitation Research and Training Centers in FY 1971 will train new personnel to enter the fields of rehabilitation and also advance the training of experienced personnel so that the vital knowledge they gain can be used to implement new and better services for handicapped and disadvantaged persons. Research environments will be improved so that new knowledge and skills can be developed to solve existing problems. These centers already have considerable impact on the State Vocational Rehabilitation programs and other State service agencies and this will be further strengthened. Center personnel will work closely with State agencies staffs, coordinating training activities with them so that the greatest effort will be aimed toward the areas needed most by the States. The training of medical and paramedical personnel and community volunteers in conjunction with the State agencies will have an important influence on the communities from which they come.

In addition, the Rehabilitation Research and Training Centers will share a significant role in the provision of rehabilitation and employment services to the disadvantaged and poverty stricken in rural and urban settings. Each Center will provide rehabilitation research and training directed to the achievement of success in effectively serving the impoverished, disadvantaged, and dependent, with emphasis upon the improvement of services for self care.

Specific research projects will focus on such high priority areas as improved work adjustment methods for motivating and training the dependent or potentially dependent for employment, new physical restoration techniques for increasing the mobility potential of the severely handicapped, and factors effecting the etiology and acquisition of cultural deprivation and mental retardation in inner city populations.

Training activities of the Centers will prepare medical and other rehabilitation related professionals and supportive personnel to work with disabled welfare and other poverty stricken citizens, to recognize characteristics important in the planning and coordination of rehabilitation services. The use of both sub-professionals and volunteers will be increased during 1971.

During the 1970 fiscal year, the Department of Health, Education, and Welfare appropriation of the three centers was \$1,075,000.

3. Division of International Activities

The Division of International Activities is the focal point for the development of all SRS international activities. These include program operations in the fields of maternal and child health, services to crippled children, social welfare, and vocational rehabilitation of the physically handicapped and the mentally retarded. As part of a reorganization of August 1967, international staff of the Welfare Administration, Children's Bureau and the Vocational Rehabilitation Administration were brought together in one unit to administer programs designed to supplement and complement domestic programs and to strengthen relationships with other countries as well as to further U. S. foreign policy goals.

A major segment of the international program has been the development and support of cooperative research and demonstration projects in certain foreign countries.

This program, financed with U. S. owned foreign currencies derived from the sale of agricultural commodities, was initiated by the Vocational Rehabilitation Administration in 1961. A vital adjunct to these research activities is the interchange of experts program authorized under the International Health Research Act. As a result of this authority, the Social and Rehabilitation Service has arranged for the interchange of scientists and experts engaged in research between the U. S. and countries participating in this cooperation program.

Since the beginning of the research and demonstration program in 1961, 22 projects in various aspects of mental retardation have been approved by the Division of International Activities. The range of research interest is very broad encompassing both medical and non-medical projects as well as clients of all ages. Types of projects that are now in progress include: investigations concerning the incidence of phenylketonuria; experimentation with new techniques for training the mentally retarded; and investigations on the medical, psychological, social and cultural aspects of mental retardation. During the past year, projects dealing with mental retardation were approved in Celon, India, Israel, Poland and Tunisia.

The Administration on Aging

1. Older Americans Act - Title III Program

Title III of the Older Americans Act of 1965 provides for funds from the Administration on Aging to stimulate the establishment of a single agency in each State to be responsible for Statewide planning, coordination, and evaluation of State activities and programs in aging, and for community service projects. Once the governor has designated such an agency and the State plan has been approved, allotments are made to the State. One allotment is for use by the State as a focal point for aging, and the responsibility it has for planning, coordination, evaluation, and administration. With the allotment for community projects the State makes grants to public and nonprofit private agencies for (1) community planning and demonstration of programs in aging; (2) for demonstration of new programs or activities beneficial to older people; (3) training special personnel for such programs; and (4) establishment of new or expansion of existing programs, including senior centers.

For example, under a Title III grant, the Boulder River Junior Chamber of Commerce, in Boulder, Montana, is operating a project called "Senior Citizens Conducting Programs for the Mentally Retarded Aged." The program was initiated because existing services and programs at the Montana State Training School and Hospital were focused on younger residents and the older population was being neglected.

During the first year of the project six older people were trained to provide services to over 100 mentally retarded aged at the School. As a result 25 of these aged residents were placed in the community during

the year, some in fulltime jobs and a few in nursing homes. During the second year, two additional older people were recruited and trained to work at the School and a part-time social worker was added to the project staff to help place and follow-up mentally retarded aged who returned to their home communities. The project expects to return about 30 additional residents from the group to their communities by the end of the year.

2. Older Americans Act - Title IV Program

Title IV of the Older Americans Act authorizes the Administration on Aging to make direct grants or to contract for research and demonstration projects of national or regional interest and value. Under a Title IV grant to the Community Service Society of New York, a demonstration project is being conducted on Staten Island in the recruitment, training, placement and retention of older people as volunteers in community service. Of the 300 volunteers, with an average age of almost 70, currently active in the program, 130 are serving at the Willowbrook State School, a 6,000-bed institution for the mentally retarded of all ages. Thirty-nine of the volunteers have been working at Willowbrook more than 2½ years.

Volunteers serve from 4 to 6 hours one or two days a week and perform such functions as feeding and playing with babies and young children, helping in the school rooms, and in the occupational therapy programs, sewing, stamping garments, and repairing toys and furniture in the shops. In addition, a group of women mend clothing for the School at the Stapleton Senior Center, and a folk dance group from another center visits the School once a week to teach dancing to teenage residents of a specially selected ward.

3. The Foster Grandparent Program

The Administration on Aging also administers the Foster Grandparent Program. The Foster Grandparent Program recruits and trains low-income men and women over 60 years of age to serve as foster grandparents to children in institutional and community settings. "Grandparents" provide two hours of individual attention to each of two children daily, and usually work five days a week.

In December 1969, there were 68 projects in 40 States and Puerto Rico. About 8,000 children in 183 institutional settings are served by 4,000 foster grandparents. Over half of the foster grandparents, or 2,720, are working with 5,440 retarded children in 75 different settings. More than 120 communities are affected by the program and many more have expressed interest in developing a project.

The work of the foster grandparents is entirely child-related, on a one-to-one basis, and aimed at providing personal attention to neglected and deprived children, not to relieve institution staff of routine care tasks. Administrative staff of institutions for the mentally retarded report that the children show improvement in self-care skills and motor skills and that, in addition, the positive results which the children show often serve to raise the morale of the institution staff.

There have been quite a few evaluations of individual Foster Grandparent projects within the past three years. All of them conclude that, based on the projects studied, the program is a viable one which has great potential for further growth. The findings of a two-year study of the program at the Denton State School, Denton, Texas, conducted by Dr. Hiram J. Friedsam and Mr. H. R. Dick, North Texas State University, concludes:

"No matter how fleeting the contact or how limited the carryover, the program does enrich the lives of the children it touches, and anyone who is familiar with institutions for retarded children will not judge this to be a minor success."

In one project for retarded children, seven children achieved the level of functioning that enabled them to enter Head Start classes; four were admitted to special education classes; one boy thought to be retarded was enrolled in summer Head Start and then registered for a regular classroom program.

Grandparents are forming a link between the community and the institutions, bringing the outside in to the children and bringing to the community a new attitude on the subject of mental retardation.

Further information may be obtained from the Commissioner, Administration on Aging, Social and Rehabilitation Service, Department of Health, Education, and Welfare, Washington, D. C. 20201.

Assistance Payments Administration

Introduction

Assistance Payments Administration's primary responsibility is to make grants to States for Public Assistance Programs under the Social Security Act passed in 1935. Old Age Assistance, Aid to Families with Dependent Children, Aid to the Blind, and Aid to the Permanently and Totally Disabled constitute the Public Assistance programs in which Federal financial participation is available to help needy individuals who also may be mentally retarded, by supplying financial aid through State-administered or State-supervised public welfare programs.

Income Maintenance

The mentally retarded person who meets a State's eligibility requirements may receive a continuing money payment while residing in his own home, a foster home, boarding home or other institution as long as need exists.

Current legislation under Titles I, IV, X, XIV and XVI of the Social Security Act limits the Assistance Payments Administration involvement with the mentally retarded to those actually receiving money payments, protective or vendor payments under a State approved plan for administering public welfare programs.

For June 1969, the estimated number of mentally retarded individuals receiving public assistance under the Federally aided programs are as follows: Total - 348,000; Old Age Assistance - 61,000; Aid to Blind - 4,000; Aid to the Permanently and Totally Disabled - 113,000; and Aid to Families with Dependent Children - 170,500.

Community Services Administration

Introduction

The Community Services Administration is the newest organizational unit of the SRS, having been established in October 1969. It carries the responsibility for the provision of Social Services under the Public Assistance and Child Welfare titles of the Social Security Act.

A. Family and Child Welfare Services

Community Services Administration administers child welfare services funds authorized by 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. The appropriation for fiscal year 1970 will be \$46 million. Although none of these funds are earmarked especially for serving the retarded, mentally retarded children are provided these services. Child welfare services, which can benefit the mentally retarded and their families, include parent counseling, homemaker services, day care services, foster family care, care in group homes, adoption services, services to unmarried mothers, and certain institutional pre-admission and aftercare services.

At the present time, all State public welfare programs provide some child welfare services for mentally retarded children. By conservative estimates of the Community Services Administration, 45,000 mentally retarded children receive child welfare services from public welfare agencies.

The "Social Security Amendments of 1967" authorize grants to State public welfare agencies for providing services to families and children receiving Aid to Families with Dependent Children. Federal funds are authorized to pay 85 percent of State costs for these services through fiscal year 1969. After July 1, 1969, Federal funds are authorized to pay for 75 percent of State costs. This program, also administered by the Community Services Administration will bring increased attention to the special needs of the estimated 133,000 AFDC children who are mentally retarded and to the family conditions in which mental retardation is often rooted.

Following are examples of developments related to the extension and improvement of family and child welfare services to mentally retarded children and their families:

A mental retardation specialist, during the three years since he was first employed by a State public welfare agency, has contributed substantially to the development of services and facilities, including specialized foster family care, from which retarded children and their families benefit. In addition, he has been instrumental in improving coordination among the State's programs for the retarded.

A State on the basis of its experience in providing the range of child welfare services through a special unit for the retarded in one locality, is not extending increased child welfare services to retarded children and their families in other areas of the State. In another State, the school of social work has a mental retardation field instruction unit located in a county public welfare department. According to the director of the county agency, this unit, which receives the support of the Community Services Administration, benefits the county in addition to providing a learning experience to the students. Increased services rendered by the students to the county's mentally retarded and their families is one benefit. The director also points out that the unit's emphasis on problems connected with mental retardation has served to "sharpen up all the (agency's) workers to give this particular problem more attention."

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. One agency through group counseling has assisted parents not only to meet the needs of their retarded children better but also to take action aimed at development of additional community programs for the retarded.

Another State public welfare agency describes its new homemaker service project as a "real success." This project provides 32 itinerant homemakers who specialize in serving families of retarded children. Through homemaker services, an over-burdened mother can be relieved of the constant and full responsibility for 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.

Another important service provided by several State public welfare agencies to assist mentally retarded children and their families is day care service. Day care services offer both constructive experiences for some retarded children and necessary help and relief for their parents. This service often may be the key factor in determining whether a child can remain with his family. In one State, the number of licensed daytime activity centers for the retarded has quadrupled, from 21 to more than 80, in about a five-year period. The State child welfare agency licenses these centers. With concern for quality in their day care programs for the retarded, some States have given special attention to the development of standards and to training of day care personnel. The value of stronger linkage between the day care center and the family is also receiving increased attention in many of these programs.

Most States provide some foster family care for retarded children. In all, it is estimated that 14,000 of the retarded children receiving public child welfare services are in foster family care.

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.

Family and 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.

Family and child welfare workers also are in a key position with regard to early casefinding, assistance with obtaining proper diagnosis and providing continuity of planning and services consistent with the needs of the individual retarded child and his family.

In spite of the efforts and potential of family and child welfare services, which have been cited, numbers of retarded children and their families need and could profit from such services not now available. Professionally skilled staff, new programs, and extension of those in existence are needed. The continuing emphasis on community services as a means of combatting mental retardation will place increasing demands on family and child welfare agencies. The need for increasing these services of the public welfare agencies is expressly emphasized by the report of the President's Committee on Mental Retardation, MR 68, The Edge of Change.

I. Training of Personnel

Training for Child Welfare Services

States are urged to provide educational leave for the training of child welfare staff. Grant-in-aid funds may be used for this purpose. 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 Amendments of the Social Security Act provided an 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 and their families is included in this program.

II. Research

Two research grant programs administered by the Community Services Administration can be used for program research assisting mentally retarded children:

A. 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.

Projects relating to mental retardation which have been completed 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) a study of specialized foster home care for deprived mentally retarded children; and (4) a study of existing laws and their administration applicable to children suffering from mental disorders, including their commitment, care, and guardianship.

Medical Services Administration

The Medical Services Administration (MSA) is the agency responsible for the administration of Title XIX of the Social Security Act.

The Mental Health Branch, Program Planning and Development Division, MSA, has the responsibility for the mental retardation activities in conjunction with the medical assistance program.

The mentally retarded who meet a State's eligibility requirements for the medical assistance program may receive the same benefits in terms of medical care, as any other recipient. The amount and scope of medical services depend on the individual State plan.

During the fiscal year July 1, 1968 to June 30, 1969, approximately \$87,000,000 in Federal funds was claimed by 11 States through Title XIX for payment of hospital and skilled nursing services for the mentally retarded in State institutions for the retarded. Those States claiming assistance were: New York, Pennsylvania, Maryland, Georgia, Illinois, Wisconsin, Kansas, Oklahoma, Texas, Utah, and California.

Rehabilitation Services Administration

Introduction

The Rehabilitation Services Administration is responsible for a broad range of programs designed both for the provision of diagnostic, treatment, and rehabilitation services for the mentally retarded, and for the support of special facilities and activities to expand and improve national resources for serving the mentally retarded. These programs include the State-Federal vocational rehabilitation program, as well as special project grants for the expansion and innovation of vocational rehabilitation services; the improvement of State residential institutions and sheltered workshops for the mentally retarded; the planning and construction of rehabilitation facilities and sheltered workshops, the construction and staffing of specialized community facilities, and the construction of university affiliated facilities for the mentally retarded; and training for professional, supportive and technical personnel already engaged or preparing to engage in occupations in the care and rehabilitation of the mentally retarded.

These diverse activities are unified by the common goal and objective of assisting mentally retarded individuals to achieve and maintain the maximum personal, social, and economic competence of which they are capable. Underlying these activities is the continuing concern for expanding the opportunities and resources available to the more severely mentally retarded.

I. Basic and Supportive Services

A. Vocational Rehabilitation Services

Under the public rehabilitation program, grants are made to State vocational rehabilitation agencies to assist them in providing rehabilitation services to mentally and physically disabled individuals who have substantial employment handicaps and who can reasonably be expected to be rehabilitated into gainful employment. Among the services provided by State vocational rehabilitation agencies are comprehensive medical, psychosocial and vocational evaluation; physical restoration; counseling; personnel adjustment; pre-vocational and vocational training; maintenance and transportation during the rehabilitation process; placement in suitable employment; services to families of handicapped people when such services contribute substantially to the rehabilitation of the handicapped client; recruitment and training services to provide new careers for handicapped people in the field of rehabilitation and other public service areas; and follow-up services to assist handicapped individuals to maintain their employment.

Recent years have seen dramatic advances in the provision of vocational rehabilitation services to the mentally retarded. The retarded now comprise nearly 13% of the rehabilitated from all categories of disability by the State-Federal program of vocational rehabilitation. In 1968, about 21,800 retardates were rehabilitated; this figure rose to nearly 30,000 in 1969; and the estimate for 1970 is 36,700.

There are many ways in which State vocational rehabilitation agencies have been organizing and developing their services for the mentally retarded. Basic to the vocational rehabilitation effort has been the growing reliance on counselors and other vocational rehabilitation staff who work only with retarded clients. This specialized staff may be assigned to local vocational rehabilitation offices, schools, institutions, sheltered workshops, or other facilities serving the mentally retarded. By concentrating their attention on the mentally retarded clients, these counselors are successfully developing rehabilitation plans based on the special problems of the retarded and are able to be broadly responsive to the needs of both the client and his family. As special vocational rehabilitation programs and facilities for the retarded continue to be developed and expanded, the number of specialized counselors within State vocational rehabilitation agencies continue to increase.

The specialized vocational rehabilitation staff working with the mentally retarded has been particularly effective in the development of cooperative vocational rehabilitation-school programs designed to assist the retarded young person to make a satisfying transition from school to work. These cooperative school programs are found in many communities throughout the country and have greatly strengthened both special education and vocational rehabilitation efforts with the mentally retarded. The cooperative program structure varies from State to State, and the variety of approaches is extraordinary. In some States, program administration is Statewide and in others there are individual agreements with individual school districts. Some programs function only to serve the mentally retarded and others include youth with all kinds of disabilities. In some States, only vocational rehabilitation and special education are administratively involved, while in others representation includes vocational education.

Most cooperative arrangements have brought about the development of vocationally oriented curricula within the schools. All of them, however, provide for a comprehensive evaluation of the retarded young person's vocational rehabilitation potential; the provision of personal adjustment and pre-vocational training; counseling; on-the-job training and work experience; job placement, follow-up and related vocational rehabilitation case services.

The number of retarded young people enrolled in cooperative vocational rehabilitation work-study programs is increasing steadily as new programs are developed. These cooperative programs have proven themselves effective in reducing the school dropout rate of retarded youngsters and have provided a technique for continuous service to youngsters during the school years when they are best able to benefit from them.

Another emphasis of State vocational rehabilitation agencies has been the establishment of rehabilitation facilities, such as comprehensive rehabilitation centers, evaluation centers, occupational training centers, workshops, half-way houses, and other specialized facilities serving the mentally retarded. Such rehabilitation facilities may be established by State rehabilitation agencies, by the State agency in cooperation with other public agencies, or by other public or private agencies.

State vocational rehabilitation agencies may assist in the construction of rehabilitation facilities in a variety of ways. They may construct new buildings; alter, expand or renovate existing buildings; purchase necessary equipment; and provide initial staffing support for a period of 4 years and 3 months. In some cases, State agencies provide direct grants to the facilities from State appropriated funds. In other cases, local facilities and workshops are supported by means of private contributions which may be used for Federal matching.

The rehabilitation of the mentally retarded is a major concern of the State agencies and this concern is evidenced both in programs directed specifically at serving the retarded and in programs in which the retarded are served in addition to other special groups of individuals. Projects for groups, such as Selective Service rejectees, welfare clients, public offenders and the economically disadvantaged have demonstrated a high incidence of mental retardation and have resulted in considerable service to the mentally retarded. By participating in multi-service centers, concerted services projects, pilot neighborhood activities and similar efforts, State rehabilitation agencies are extending their services in order to reach and rehabilitate greater numbers of retarded persons living in both rural and urban poverty.

Several special programs have been initiated over the past few years to develop job opportunities for the retarded. One of these, the program for Federal employment of the mentally retarded has been eminently successful, with more than 6,100 placements in 100 different job titles at Federal installations across the country. The retention rate for these retardates has been far superior to that of other employees in similar positions; and the program has recently been written into the permanent personnel policy of the U. S. Civil Service Commission. All retarded applicants for Federal employment are certified as job-ready by the appropriate State rehabilitation agency.

Special project grants for the innovation and expansion of vocational rehabilitation services have also been utilized to extend and improve State rehabilitation agency efforts for the mentally retarded. Innovation grants provide the means for State agencies to develop new programs and techniques in order to adapt to changing needs, while expansion grants are designed specifically to increase the number of people rehabilitated by the State agency.

Under the Innovation Grant Program, a new project is providing prevocational training for the mentally retarded at the Roswell (New Mexico) Vocational Evaluation and Adjustment Center. A rehabilitation facility is being developed at the Boulder River School and Hospital, Montana, under an Innovation grant; this is serving both residential and non-residential retardates in the region. Other Innovation grants have supported the development of an evaluation unit for the visually handicapped retardate at a State institution in Pennsylvania, and the establishment of a vocational center at the Idaho State School and Hospital for the Mentally Retarded.

An Expansion grant is supporting the cooperative development of a rehabilitation program by the New Orleans Association for Retarded Children and the Dr. Russell L. Holman Vocational Center for Retarded Girls. Another grant of this kind is being utilized in the State of Washington to underwrite expansion of a Yakima workshop into a box factory to provide employment for mentally retarded persons. The Expansion grant program has also supported the growth of sheltered workshops for the retarded in Alaska, Indiana, Louisiana, Massachusetts, Nebraska, Oregon and Pennsylvania.

Within an extensive program of rehabilitation facility improvement, the Rehabilitation Services Administration administers Workshop Improvement grants designed to upgrade the services of sheltered workshops and other facilities by supporting such activities as the employment of additional staff, technical consultation, staff development, and the purchase of rental or equipment.

During fiscal year 1969, 182 Workshop Improvement Grants totaling \$4,068,000 were awarded to sheltered workshops, many of which were affiliated with local associations for retarded children. Workshop Improvement Grants were also awarded to residential institutions for the mentally retarded to improve their sheltered workshop programs.

Other rehabilitation facility improvement activities are: (1) a program of technical assistance consultation by means of which contracts may be made with State vocational rehabilitation agencies or with other expert consultants to provide workshops and other facilities with special consultation services; and (2) projects to share in the cost of providing training services for handicapped individuals in public or other non-profit workshops and rehabilitation facilities. Federal financial participation in the Training Services grant program may assist in the cost 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.

During fiscal year 1969, Training Services Grants totaling \$5,730,000 were awarded to 36 workshops serving the mentally retarded as well as other disabled persons.

B. Social Services for the Aged and Handicapped

The Community Services Administration is responsible for the promotion and maintenance of standards for social services provided by State and local public welfare agencies on behalf of aged and disabled public assistance recipients. Such services are directed toward strengthening individual and family life and helping needy individuals attain the maximum economic and personal independence of which they are capable. Among the disabled clients within the Aid to the Permanently and Totally Disabled Categories is an estimated 127,000 mentally retarded adults. No reliable information is available to estimate this for Old Age Assistance and Aid to the Blind.

While there are many special problems and conditions which are of concern to the public assistance programs, mental retardation has

particular significance as a frequent cause of economic dependency. Many of these retarded persons cannot live in the community unless special protective services are provided in their behalf. These social services are particularly essential when family members through incapacity or death can no longer provide a protective environment.

Homemaker services, group work services, foster family care, group and volunteer services, and use of additional specialists, such as teachers, psychologists, and counselors, can make special contributions towards meeting the needs of the mentally retarded. Public welfare agencies are responsible for participating with the total community in developing diagnostic treatment, training and employment services, for the mentally retarded, and for developing basic social services to support, encourage, and sustain the mentally retarded in areas of family and social functioning.

The various State public welfare agencies may elect to provide as a minimum the following services: (a) those providing protection for the individual; (b) those which help the client remain in or return to the community; and (c) those services appropriate for self-support. Other services -- to persons with potentials for self-care, to those estranged from family, and to those who are former and potential public assistance applicants and recipients -- may be provided in addition. Special programs providing homemakers, volunteers and groups services may also be furnished in addition to the minimum services. When the States elect to provide these services, Federal matching in the amount of 75 percent is available to meet such costs. About two-thirds of the States have elected to provide at least the minimum services and a further expansion of social service is being encouraged.

C. Mental Retardation Hospital Improvement

The Mental Retardation Hospital Improvement Grant Program is designed to assist State institutions for the mentally retarded to improve their care, treatment, and rehabilitation service. The program is specifically focused on the demonstration of improved methods of service and care, as opposed to research exploration or the development of new knowledge.

Only State residential institutions for the mentally retarded are eligible to apply for these grants. These State institutions are defined as those residential facilities under the administrative direction of State agencies responsible for such institutions. The maximum amount of support, including direct and indirect costs, that an institution can receive under this program for any one budget period (usually 12 months) is one hundred thousand dollars (\$100,000). Individual projects are normally approved for no more than a five-year period. Projects are planned in response to high priority needs in relation to the overall institution plan and are directed toward the ultimate improvement of resident care throughout the institution.

An analysis of the current Hospital Improvement projects shows that a majority of the projects is 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 severely retarded and dependent residents are emphasizing personal development by means of self-care training, socialization experiences, intensive medical diagnosis and treatment, and opportunity for improved speech.

A number of projects have focused on special program areas, such as prevocational training for adolescents, and programs of treatment, training, and social habilitation. Other projects provide a diversified range of improved services, such as placement preparation, speech therapy, medical-physical diagnosis and treatment, recreation services, social-vocational habilitation, diagnostic study with improved records and program planning and use of the unit system, all of which enhance the development of an institution-community continuum of services.

The Mental Retardation Hospital Improvement project grant program was initiated in 1964 as an extension of the Mental Health project grant program. In fiscal year 1969, 97 projects in 91 State institutions for the mentally retarded had received awards. There are 181 eligible institutions at this time. This means that approximately 50 percent of the rapidly increasing number of eligible institutions are included in the program.

Major emphasis in this program during the next year will continue to be placed both on the extension of coverage to those institutions not yet involved in the program and on the development of long-term collaborative efforts by the staffs of the institutions receiving grants, their State mental retardation agencies, and the Rehabilitation Services Administration. Such collaboration is being developed so that project experience in solving problems of institutional care of the mentally retarded may be assessed and shared to ensure that improved methods and techniques can be widely disseminated.

The coordination of institutional programs with community service programs and Statewide comprehensive planning activities remains an important objective of the Mental Retardation Hospital Improvement Program.

D. Community Services

Although Community Service projects are administered in the Office of Community Health Service of the Health Services and Mental Health Administration, Public Health Service, the Division of Mental Retardation within the Rehabilitation Services Administration actively stimulates such projects and encourages their submission for competitive evaluation and support.

High priority is given project proposals directed to programs to individuals with moderate to profound intellectual impairment through

special health services which could not usually be available through programs presently serving the general population. Grants are available through programs presently serving the general population. Grants are available for projects devoted to: (1) new or expanding existing programs to serve the mentally retarded and their families; (2) proposals designed to reflect multiple agency funding when possible; (3) proposals involving the utilization of disadvantaged persons in the program when appropriate; and (4) those involving such activities as community-wide planning, coordination and/or citizen participation as well as the provision of special health-related services such as homemaker services, special therapeutic recreation, or information and referral services.

The first area of priority is being given to projects in target cities, which provide unmet services to the retarded in model cities, ghettos, neighborhood health centers, family planning or coordinated health programs.

II. Training of Personnel

A. Training Grant Programs

The Rehabilitation Services Administration supports a variety of training grant programs designed to increase both the supply and competence of professional and subprofessional personnel qualified to provide rehabilitative, health and other services to the mentally retarded. Included within the training activity are: (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 residential institutions for the mentally retarded and State vocational rehabilitation agencies for in-service staff training; (4) contracts with educational institutions and other agencies to support short-term training programs; and (5) grants to public and private nonprofit agencies and organizations for a program of student work experience and training in mental retardation.

Under the Vocational Rehabilitation Act during fiscal year 1969, there were 38 long-term teaching grants supported at 32 different institutions or organizations, including 30 universities. There were also 7 short-term training grants during this same period. The long-term grants supported the professional education of specialists in social work, speech pathology, and audiology, rehabilitation counseling and physical therapy with 289 traineeships awarded in these areas including 4 traineeships awarded by the Research and Training Center at the University of Oregon and 10 by the Research and Training Center at the University of Wisconsin. Short-term courses were largely conducted by three RSA-supported centers for short-term training in mental retardation--University of North Carolina, Columbia University and California State College at Los Angeles. These courses reached 874 students during 1969. The total amount obligated by RSA in fiscal year 1969 for support of training of rehabilitation personnel in mental retardation was 1,734,546. It is estimated that the 1970 total will be about the same.

Rehabilitation Services Administration activities in fiscal year 1970 in the field of professional preparation include:

- Maintaining level of students in graduate training programs in psychology, social work, rehabilitation counseling, physical therapy, speech pathology and audiology receiving specialized training in the rehabilitation of the mentally retarded through supervised field work in mental retardation settings;

- Improvement in curriculum content and teaching methods in training projects through support of field teachers, the development of case material and other teaching aides, the encouragement of research in the rehabilitation of the mentally retarded, and training courses dealing with the scope, nature and place of content on mental retardation in the curriculum. The teaching films produced by Parsons State Hospital, for example, were completed in fiscal year 1969 and are now ready for distribution and use by rehabilitation personnel.

- 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, interdisciplinary approach to providing care and rehabilitation of the mentally retarded through training courses focused on interdisciplinary program planning and operation of rehabilitation services;

- Stimulation of training programs for assistant or aide positions in such fields as physical therapy, occupational therapy, social work and 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 personnel 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.

Based upon continuation of 1969 projects, 1970 grants made by the RSA will include:

B. Multi-Disciplinary Programs

California State College at Los Angeles;
Columbia University, Teachers College
Devereux Foundation
University of North Carolina

In addition, the SRS-supported Research and Training Centers (Mental Retardation) receive RSA training funds for support of stipends for graduate students. They are the Universities of Oregon, Texas and Wisconsin.

C. Field Instruction Units

1. Rehabilitation Counseling

University of Florida
Michigan State University
University of Oregon
State University of New York at Buffalo
Southern Illinois University
West Virginia University
University of Wisconsin, Madison

2. Social Work

Boston College
University of California (Berkeley)
University of California (Los Angeles)
University of Connecticut
University of Denver
Louisiana State University
University of Louisville
University of Michigan
New York University
University of Puerto Rico
Rutgers -- The State University
San Diego State College
Syracuse University
University of Texas
Tulane University
University of Utah
University of Washington
University of Wisconsin (Madison)
University of Wisconsin (Milwaukee)

3. Speech Pathology and Audiology

Michigan State University

4. Physical Therapy

University of Oklahoma

5. Occupational Therapy

Parsons State Hospital

Short-term training in mental retardation is being conducted by the three RSA training centers and the Research and Training Centers.

The long-term multidisciplinary training programs at the University of Wisconsin, the University of Oregon and the University of Texas are now operating within Social and Rehabilitation Service Research and Training Centers. Long-term traineeships at these Centers are supported by Rehabilitation Services Administration funds and 14 such traineeships were awarded by the Research and Training Centers in fiscal year 1969. Although the underlying content and intent of the multidisciplinary courses supported under the Vocational Rehabilitation Act 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.

D. Hospital Inservice Training

The Hospital Inservice Training grants have been designed to provide a means for increasing the effectiveness of employees in state residential institutions for the mentally retarded.

Eight-six of the 181 eligible State residential facilities are receiving a total of \$1,832,000 through the Hospital Inservice Training program and are translating the rapidly expanding body of knowledge about practices in the care of the mentally retarded into more effective services.

Hospital inservice training has been 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 of personnel which will result in an improved quality of care for the mentally retarded residing in institutions.

Because personnel such as attendants, houseparents, aides, and others in similar personnel categories comprise the major portion of those rendering direct care to institutionalized retardates, the first major area of grant support was extended to these personnel. Grant support is available for inservice training of all professional, sub-professional, and technical personnel who have direct responsibilities for resident care and training.

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 five years and are renewable.

There are four general types of training supported by inservice training grants to institutions for the mentally retarded: (a) initial on-the-job training for employees; (b) refresher, continuation, and other special job-related training courses; (c) continuation training for technical and professional staff to keep them informed of new developments in their fields which can be translated into more effective patient service; and (d) special instructor training for staff with inservice training responsibilities aimed at providing a cadre of personnel to continue and extend the institutional training program.

The content of the training programs includes general instruction in the areas of mental retardation; child growth and development; nursing care skills; patient-staff relations; human behavior; intra-staff relations; supervisory skills; communications skills; and adjunctive therapy skills.

Consultation is given to the institutions which have received grants to assist them in making the best use of training opportunities. Technical information and professional consultation is being provided to the remaining State institutions for the mentally retarded in order to enable them to qualify for similar grants.

E. Project Grants for Rehabilitation of the Mentally Retarded

The program of Project Grants for Rehabilitation of the Mentally Retarded is administered by the Division of Mental Retardation, Rehabilitation Services Administration, of the Social and Rehabilitation Service. Any questions or requests for clarification should be directed to the appropriate DHEW Regional Office.

The purpose of project grants administered by the Division of Mental Retardation under the provisions of Section 4(a)(1) of the Vocational Rehabilitation Act, as amended by the Vocational Rehabilitation Amendments of 1968, is to pay part of the cost of organized, identifiable activities which are undertaken to contribute to the rehabilitation of mentally retarded individuals generally not eligible for vocational rehabilitation services. Grants provide for expansion or establishment of programs serving the mentally retarded, application of new techniques for rendering services, coordination of resources and information, and for increasing the number and types of specialized personnel working with the retarded.

The activities undertaken should stimulate the development, and encourage the utilization of community facilities and services for the mentally retarded such as:

- (a) Establishment of special services for the diagnosis, treatment, training, or care of the mentally retarded;
- (b) Demonstration projects in the rehabilitation of the mentally retarded; or
- (c) Training, including inservice training and education of personnel in all fields or disciplines which contribute to the rehabilitation of the mentally retarded, through the provision of training, teaching, or traineeship grants.

Projects may include, but are not limited to, activities such as the following:

- (1) Utilization of newly developed techniques and methods that have been found to be effective in the rehabilitation of the mentally retarded.
- (2) The extension of mental retardation programs and activities to areas of urban or rural poverty.
- (3) The initiation or expansion of programs for mentally retarded individuals with special problems such as multi-handicapped

adolescents or mentally retarded adults who might not be eligible for vocational rehabilitation services or mentally retarded children who cannot profit from available educational or vocational rehabilitation programs.

- (4) The initiation, expansion, and extension of present rehabilitation services in order to serve additional numbers of mentally retarded persons.
- (5) Special training of personnel in disciplines or occupations contributing to the rehabilitation of the mentally retarded.
- (6) Student Work Experience and Training (SWEAT) to provide a guided work experience program to help young people learn about career opportunities in mental retardation while serving the retarded.

Applications for Project Grants for Rehabilitation of the Mentally Retarded may be made by States and public or other nonprofit organizations, agencies, and institutions, including universities and other educational institutions. However, no Federal financial assistance may be furnished under this program for activities for which payment is made under another Federal authority.

III. Construction

A. Community Facilities for the Mentally Retarded

The community facilities construction program authorized under Title I, Part C of the "Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963" (P.L. 88-164) provides Federal grants to States to assist in the construction of specially designed public or other nonprofit facilities for the diagnosis, treatment, education, training, or custodial care of the mentally retarded, including sheltered workshops which are part of a facility providing comprehensive services. The program is administered at the State level by an officially designated State agency. Participation in the program requires the development of a State plan for the construction of community facilities for the mentally retarded based on an inventory of needed additional services and facilities. Construction projects are approved in accordance with the provisions of the State plan.

As of November 1969, 297 projects have been approved. Eighty-eight facilities are completed and in operation, and 88 additional facilities are under construction. These facilities will provide care and treatment for approximately 30,000 additional retarded persons not now being served. The estimated total cost of these projects is over 158 million with an estimated Federal share of over \$61 million.

The program is having a widespread impact on community efforts to meet the needs of the retarded. Public and voluntary agencies are demonstrating 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 only slightly touched on the need for additional services and facilities. State plans indicate that services should be provided for about one million additional retarded individuals.

Special consideration is to be given in programming and allocation of grant funds to urban and rural poverty areas. It is estimated that approximately 60 new projects will be funded, utilizing approximately \$8 million available for the construction of community facilities in fiscal 1970.

B. Construction of Rehabilitation Facilities

The Vocational Rehabilitation Amendments of 1965 (P.L. 89-333) authorized a program for the construction of rehabilitation facilities and workshops; the construction of rehabilitation facilities and sheltered workshops; and initial staffing support for newly constructed rehabilitation facilities and workshops. Special provisions are made to permit the inclusion of residential facilities within projects for the construction of workshops for the mentally retarded.

State Planning grants for workshops and rehabilitation facilities encompass: (1) the development of State Workshop and Rehabilitation Facilities Plan; and (2) construction, utilization, development, and improvement of workshops and rehabilitation facilities.

Project Development grants pay part of the cost of organized, identifiable activities necessary for the planning and development of specific local construction projects for rehabilitation facilities or workshops. These projects are 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 1969, 59 Project Development Grants, having a national average of \$3,000, were made to applicants planning a specific construction project providing services to the mentally retarded and other disabled persons.

Construction grants assist in the costs of the new construction of rehabilitation facilities and workshops; the acquisition, expansion and alteration of existing facility and workshop buildings; initial equipment for the completed projects.

Thirty-one construction grants totaling about \$2,330,000 were awarded during fiscal year 1969. These projects were for the construction of workshops, and comprehensive rehabilitation centers. Most of these projects are multidisability in nature and serve the mentally retarded as well as other disability groups. Workshops serving the retarded were constructed in West Columbia, South Carolina, Montpelier, Vt., and Wausau, Wisconsin.

C. University-Affiliated Facilities for the Mentally Retarded

The University-Affiliated Facilities for the Mentally Retarded program assists universities or affiliated facilities for the mentally retarded in the construction of special clinical facilities capable of demonstrating exemplary care, treatment, education and habilitation of the mentally retarded. In University-Affiliated Clinical facilities comprehensive services are provided; specialized personnel are trained; or new techniques of specialized service are demonstrated.

The primary purpose of this program is to provide facilities for the clinical training of physicians and other professional and technical personnel in the field of mental retardation. Among the professional disciplines represented in these facilities are medical personnel, dentists, nurses, speech and hearing therapists, nutritionists, physical therapists, occupational therapists, rehabilitation specialists, special educators, psychologists, social workers, recreational specialists and chaplains. Each facility is encouraged to conduct a comprehensive multidisciplinary training program so that each discipline involved in the care and rehabilitation of the mentally retarded may be fully familiar with the contributions of the other disciplines.

The Mental Retardation Amendments of 1967 (P.L. 90-170) extended the university-affiliated construction program until June 1970. The present law was also amended to provide grants for the construction of university-affiliated facilities which include programs for persons with other neurological handicapping conditions related to mental retardation and for research incidental or related to activities conducted within the facility.

Because of the complexity of the university-affiliated program, individual planning grants are available. Such individual grants may not exceed \$25,000 nor more than 75 percent of the planning costs.

Approved projects for the construction of university-affiliated facilities for the mentally retarded are: Children's Rehabilitation Institute, Reisterstown, Maryland; University of Colorado, Denver, Colorado; Walter E. Fernald State School, Waltham, Massachusetts; Children's Hospital Medical Center, Boston, Massachusetts; Georgetown University, Washington, D. C.; University of California Neuropsychiatric Institute, Los Angeles, California; University of Alabama Medical Center, Birmingham and Tuscaloosa, Alabama; Indiana University Medical Center, Indianapolis and Bloomington, Indiana; University of North Carolina, Chapel Hill, North Carolina; University of Tennessee, Memphis, Tennessee; New York Medical College, New York, New York; Georgia Department of Public Health, Atlanta, and Athens, Georgia; University of Oregon, Portland, Oregon, and Eugene, Oregon; University of Miami, Miami, Florida; Utah State University, Logan, Utah; The University of Kansas, Lawrence, Kansas City and Parsons, Kansas; University of Wisconsin, Madison, Wisconsin; and Ohio State University, Columbus, Ohio.

IV. Initial Staffing of Community Facilities for the Mentally Retarded

The Mental Retardation Amendments of 1967 (P.L. 90-170) added a new program to stimulate and aid local communities in responding to the unmet needs of the retarded by providing grants to pay for the initial cost of professional and technical personnel in the operation of new facilities or for new services in existing facilities for the mentally retarded. Over eight million dollars was appropriated in 1969 fiscal year to implement the program. Of this amount, approximately 50 percent was used to support 95 projects serving residents of model cities.

Grants were approved for a total of 237 individual projects sponsored by local nonprofit community organizations or public agencies to benefit over 60,000 retardates.

Grants are made on a declining basis for 51 months. During the first 15 months, the grant may not exceed 75 percent of the cost; 60 percent for the next year; 45 percent for the third year; and 30 percent for the last 12 months.

For fiscal year 1970, approximately \$12 million will be available for new projects and to continue grants previously approved.

Funding of new projects terminated in the Spring of 1968; however, some projects were extended through December 1968. Indications are that in a majority of the States these planning and implementation activities are continuing and will continue under State sponsorship on a permanent basis, thus providing conformity and assuring coordinated services to the mentally retarded. Consultation from the Federal level will also continue, including analysis of data coming out of the planning and implementation projects.

V. Mental Retardation Information

A. Collection and Dissemination of Information

Since September 1968, the special mental retardation review, abstracting and information activity has been operated as part of the Division of Mental Retardation/RSA, Social and Rehabilitation Service. In previous years, this service was a 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 Social and Rehabilitation Service under contract with the American Association on Mental Deficiency, collects current literature on mental retardation, writes informative abstracts, indexes the literature in depth and compiles annotated bibliographies on special topics.

Special annotated bibliographies have been prepared on: (1) Programmed 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; (15) A Selected List of Teaching Materials Regarding Mental Retardation for Faculty of Schools of Social Work; (16) Architectural Planning for the Mentally Retarded to Remove Barriers and Facilitate Programming; (17) Inservice Training in Institutions for the Mentally Retarded; (18) Behavior Modification of the Mentally Retarded; (19) Dental Care for the Mentally Retarded.

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; (13) Application of Operant Conditioning Techniques to Institutionalized Severely and Profoundly Retarded Children; (14) Adaptive Behavior: A New Dimension in the Classification of the Mentally Retarded.

The abstracts and annotated bibliographies appear in the quarterly journal Mental Retardation Abstracts, which is distributed gratis to approximately 8,500 individuals engaged in research and practice in mental retardation and is for sale by the Superintendent of Documents.

B. Mental Retardation Institutional Reporting Program

The Division of Mental Retardation has the responsibility for conducting a nationwide survey to determine the number of public mental retardation institutions, the extent of their utilization, and the characteristics of the persons served in these facilities.

Data are published annually in two portions; the first provides administrative information relating to resident patient movement, number of personnel and maintenance expenditures, while the second portion depicts the admissions and residents in terms of age, sex, medical classification and level of retardation.

C. Films and Publications

The Rehabilitation Services Administration continues to distribute a documentary film, "Handle with Care," stressing the value of a fixed community point of referral upon which the families of the mentally

retarded can depend for continuing lifetime guidance and assistance in obtaining appropriate services. The film has been placed in State health departments and medical school film libraries for wider distribution.

A second film, "Teaching the Mentally Retarded--A Positive Approach," a documentary dealing with behavior shaping, was placed in circulation during 1967. It is aimed at child-care workers and attendants as well as students who are preparing to work with the mentally retarded.

A third film was produced in 1968. This film "A Way Out of the Wilderness" depicts care, treatment, and training activities in a private institution and a large State institution for the mentally retarded. The film was developed to sharpen the awareness of the general public to today's problems and promises in institutional care for the retarded.

A package of training materials for parents of retarded children and personnel in residential and day facilities for the retarded provides information on training mentally retarded children in feeding skills and toilet use. The materials which include filmstrips, records, a discussion guide and pamphlets provide helpful directions for both individual and group training in these two basic skills which are a major step toward self-care and increased independence.

All of the above are available free on a short-term loan basis from:

National Medical Audiovisual Center (Annex)
Station K
Atlanta, Georgia 30324

Numerous publications have been prepared and placed in circulation. One in particular, "A Modern Plan for Modern Services," states the basic philosophy of the Division of Mental Retardation in 6 major points. Briefly stated, these points emphasize: (1) utilization of generic community agencies in lieu of establishing specialized services; (2) provision of basic training in mental retardation for every category of service personnel; (3) definition for utilization of specialized services and agencies; (4) placement of a mental retardation specialist in every generic agency; (5) development of standards for service and training; and (6) coordination within the community.

Three other publications are worthy of note: (1) Opportunity: Help for the Mentally Retarded, provides a brief description of rehabilitation services available to the retarded, eligibility requirements and a list of the State rehabilitation agencies where further information may be acquired; (2) A Mental Retardation Film List, sponsored by the Division of Mental Retardation provides a list of films of interest to both professional and to the general public and brief descriptions of each film and the sources from which each may be borrowed, rented and/or purchased are included in the pamphlet; Atlas of Mental Retardation Syndromes, an 188 page reference textbook for physicians which presents a concise review of clinical features, pattern of inheritance, laboratory and x-ray findings, recommended therapy, and current references of 83 syndromes.

SOCIAL SECURITY ADMINISTRATION

Purpose

The basic purpose of the social security program is to provide cash benefits to replace, in part, earnings that are lost to individuals and families when earnings stop or are reduced because the worker retires, dies, or becomes disabled, and to provide health insurance protection to persons 65 and over. The program is contributory, it is self-supporting, benefits are wage-related, and entitlement to benefits is an earned right .

Historical Development

In 1935, when the original social security law was passed, the 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--not only for disabled workers, but also for adult sons or daughters (who became disabled before age 18) of disabled, retired, or deceased workers--was provided by the 1956 amendments. In 1965, health insurance benefits for the aged were added. The 1967 amendments provided benefits for disabled widows and widowers age 50 and over. Since 1949, there have been six general benefit increases in recognition of the fact that prices and wages have gone up.

Economic Impact

Mental deficiency is a major factor in more than 65 percent of cases involving dependents or survivors who have been continuously disabled since childhood. It is the primary diagnosis in about half of all childhood disability cases. In fiscal year 1969, an estimated 162,000 mentally retarded adults disabled in childhood and 8,000 mentally retarded workers received \$139 million.

The regulations contain guides as to the level of severity required in disability cases involving mental retardation. These regulations (published in 1968) have the effect of law and are available to the public and the medical community.

The number of mentally retarded children under age 18 who receive payments as dependents of retired, disabled, or deceased workers is unknown, since their benefits are payable regardless of disability.

Under social security's "Childhood Disability" provisions, lifetime monthly payments can be made to a person age 18 or over who has been disabled by mental retardation--or other impairments--since childhood. In many cases, the monthly benefits enable the retarded childhood disability beneficiary to be cared for at home instead of in an institution. Furthermore, as more and more retarded people outlive their parents, the program offers reassurance to fathers and mothers who know that financial help for their disabled child will be forthcoming even after their death. (About half of the childhood disability beneficiaries are over 35 and 25 percent of them are over 45.)

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.

Health insurance benefits under the social security law are available to any individual, including a mentally retarded individual who is 65 or over and who meets certain necessary conditions. Therefore, a mentally retarded individual 65 years of age who has contracted an illness or suffered an injury is, like any other person in this age group, protected under the health insurance program. However, the health insurance for the aged program specifically prohibits reimbursement under the law for expenses incurred for personal care designed primarily to aid an individual in meeting the activities of daily living and which do not require the continuing attention of trained medical or paramedical personnel. Therefore, an aged mentally retarded person whose only deficiency is mental retardation requiring general institutional care, e.g., vocational training, help in the activities of daily living, and so forth would not be receiving the type of care covered under the Medicare program.

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. The service is provided to beneficiaries as well as to non-beneficiaries and applicants who inquire about services not provided by the old-age, survivors, disability, and health insurance program. Disabled persons applying for disability benefits under social security are promptly referred to the Rehabilitation Services Administration to the end that the maximum number may be rehabilitated into productive activity or to a level of self-care.

SSA has participated in the employment of the mentally retarded since the inception of the employment program in 1964. It has also tried, through the coordinator for employment of the handicapped, to generate interest in the program of private employers and other Federal agencies. Experience has demonstrated conclusively that the retardate can perform excellent work in basically routine positions when placement is carefully selected or the job re-engineered to the level or degree of his handicap. The ultimate goal in recruiting and hiring the mentally retarded is to assist in their rehabilitation to a productive life. In SSA, retardates are successfully performing in such positions as mail and file clerk, messenger, operators of printing, xerox, and card reader machines.

Retardates are performing so well many have been promoted to grades GS-2 and GS-3. One has qualified on a competitive examination and has been converted to a career-conditional appointment. Another was nominated by her supervisor as the "Outstanding Handicapped Employee

of the Year." The Social Security Administration is initiating a training session for first-line supervisors to bring about better understanding of the retarded employee.

As of September 30, 1969, a total of 119 retardates were on duty as follows: 36 in central headquarters offices, 43 in payment centers, and 40 in district offices.

In the area of public information, a new publication, "What Families of Persons Disabled by Birth Defects Should Know about Social Security Benefits" was developed in cooperation with the national foundation--The March of Dimes. One thousand affiliates of the national foundation will receive copies, and requests for additional copies will be channeled to SSA.

In June 1969, the Social Security Administration released a 20-minute film on mental retardation, "Where There is Hope." The film, in color in both 35 mm and 16 mm for theatrical and general showing, tells of the social security benefits available for the adult disabled child. It depicts teenagers and older people at work in a sheltered workshop in Washington, D. C., diagnosis and therapy at the John F. Kennedy Institute in Baltimore, and the trial work period of a beneficiary in Greensboro, North Carolina. A 14 1/2-minute version is being distributed as part of the "Social Security in America" series, which is shown on 220 television stations throughout the country. District offices have contacted State associations for retarded children to offer them the film.

The Social Security Administration had distributed some 200,000 copies of a pamphlet, "Social Security: What It Means for the Parents of a Mentally Retarded Child" in 1969. The leaflet, available in both English and Spanish, describes the conditions under which a mentally retarded child may be eligible for social security benefits.

The 1967 Survey of Institutionalized Adults conducted by the Social Security Administration collected basic information on the socio-economic characteristics of mentally retarded and other disabled persons aged 18 and over in institutions such as homes and schools for the mentally and physically handicapped, mental hospitals, chronic disease and other long-term hospitals. Data was obtained from institutional records and from relatives and guardians. The survey focused on types of care, cost of care, sources of payment, economic resources of the patient and his family, and his social relationships with family and friends. The handling of the institutionalized person's economic resources by administrators (including the institution) and payees was also examined. Data from this study will be available for analysis early in 1970 and published reports by the fall of 1970.

The Social Security Administration chaired an intra-departmental task force which studied and evaluated a proposal to establish a national social insurance program designed to provide help to families with mentally retarded children. In issuing its report, the Task Force concluded that there is need for much further study in this area before it would be practical to develop a social insurance program for the mentally retarded children and recommended that further study on the problems facing the mentally retarded and their families be undertaken by a research-oriented group or agency.

CONSUMER PROTECTION AND ENVIRONMENTAL HEALTH SERVICE

Introduction

The activities of the Consumer Protection and Environmental Health Service which have an impact on mental retardation are confined primarily to the Food and Drug Administration.

The Food and Drug Administration is directed by statute to develop and enforce valid criteria for the testing, identification, and proper labeling of drug products hazardous to consumers in use or misuse, and to ban from the market foods, food additives, pesticides, drugs, devices, or cosmetics considered either unsafe or misbranded.

As defined by the Federal Food, Drug, and Cosmetic Act, a new drug is one not generally recognized by qualified experts as safe and effective for the recommended use. A new drug may not be distributed in interstate commerce until the sponsor submits to us and we have approved a new drug application with adequate evidence of safety and effectiveness for the intended use.

A new drug may be distributed for investigational study by qualified experts in accordance with the requirements of the Investigational Drug Regulations. These regulations require, among other things, that before an investigational drug may be distributed interstate, some responsible individual or firm must sponsor clinical study with the drug. This is usually accomplished by the submission of a completed and signed Notice of Claimed Investigational Exemption for a New Drug accompanied by the pertinent data which the form outlines.

When the investigational drug is employed solely as a research tool, and occasionally in early clinical investigations which have therapeutic potential, an abbreviated submission which furnishes the essential information in narrative form may be acceptable.

I. Preventive Services

The Food and Drug Administration is concerned with preventing mental retardation that might follow the use or misuse of drugs or hazardous substances. The special age of concern is the reproductive age. The vulnerable periods are those specifically of embryonic, fetal, and infant life. Dosage levels considered safe in older infants may be potential causes of permanent brain damage in the prenatal or newborn age group which possess immature mechanisms of detoxification of these drugs. Infants cannot handle drugs as well as adults because of lack of development of an enzyme system.

Mental retardation can be defined to limit it to the impairment of the learning ability, or extended to include the lack of emotional response. Whether or not mental retardation is defined to include mongoloids, persons suffering from degenerative diseases such as Parkinsonism, institutionalized mental patients, or others, FDA is concerned with the use or abuse of drugs intended to prevent or treat such conditions. Much of the work in this area is so specialized that it is performed by individual investigators rather than by drug companies.

In the Bureau of Medicine, the Office of New Drugs monitors the investigational use of new drugs in early testing phases. Animal experimentation is required to prove a new drug safe and effective before that drug may be tested on human beings. Observations of adverse effects of new drugs are reported within the surveillance system of the administration.

FDA expects investigators to set up metabolic methodology on new entities, at least to attempt to develop functional toxicology and biochemical toxicology, relating experiences of one species to those of another, eventually to experiences of man.

The Food and Drug Administration also is concerned with the treatment of mental retardation. Special diets and drugs may or may not be effective. Regulatory action is taken against drugs or devices that are represented to be useful in the prevention or treatment of mental retardation but in fact have no such beneficial effect.

Surveillance by the Food and Drug Administration also covers any untoward effect of chemical entities used in foods, drugs, cosmetics, or household chemicals. These data are acquired in close liaison with many hospitals, with the American Medical Association, the World Health Organization, the pharmaceutical industry, and with other health, education, and welfare agencies. This information is catalogued, retrieved, and evaluated by means of an advanced data processing system.

SURPLUS PROPERTY PROGRAM

The Office 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, as amended, which make surplus Federal real and personal properties available for health and educational purposes. 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 which may be needed and usable by eligible institutions throughout the country in conducting health and educational programs. Properties determined to have such need and usability 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. These State agencies secure the properties, warehouse them, and make the distribution to eligible donees for health and educational uses within their respective States. The only costs 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 Representatives for Surplus Property located in 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 applied against the sales price. 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 applied against the sales price. The only other costs to eligible transferees are "out of pocket" Federal costs, 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 nonprofit 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.

An applicant for real property must be a State, or a political subdivision or instrumentality thereof; a tax-supported educational or public health institution; or a nonprofit 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 fundamentally for an 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. Real property may be put to a joint use, namely, for the training of the mentally retarded as well as the physically handicapped. 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.

Available personal property may range anywhere from a nail to an electronic computer. Many items have never been used before. Real properties may 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 property, 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 Office of Surplus Property Utilization, 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.

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 was established on 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 Arizona Children's Colony obtained 30 acres of land at the Davis Monthan Air Force Base in July 1967 as a site for the new "Mental Retardation Center at Tucson." Plans are to construct 6 buildings initially, including 3 residential units. These buildings will provide residential care facilities for approximately 84 residents and day care facilities for 150 to 200 people in the Tucson area, many of whom were cared for far from their homes. In addition, the facilities will provide space for a preschool program for children not yet determined to be retarded, vocational training and rehabilitation therapy, consultation services, and, in cooperation with the University of Arizona, training and research. Future plans are to enlarge the Center into a facility which will have approximately 200 beds for residents and space for 300 to 400 day care persons.

The former Sunmount Veterans Hospital Reservation, Tupper Lake, New York, consisting of 111 acres of land improved with 44 buildings and installed equipment, was conveyed to the State Department of Mental Hygiene to provide a complete program of care, treatment, education, and rehabilitation of mentally retarded children and adults. The State first took over the hospital under a permit agreement in 1965,

and the majority of the staff remained to operate the new program. Nurses were assigned to the three operating State schools for orientation courses in the care of the mentally retarded. Upon their return to Tupper Lake, the first group of patients was transferred to the new facility. Since that time, this 506-bed hospital has been operated to serve mentally retarded persons of all ages, drawn from the five upstate New York counties.

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. Plans call for 10 of these Centers having capacity of approximately 1,000 resident students each. One of these Centers which serves the northwest section of the State, has been established at Marianna on 372.67 acres of land and 65 buildings, formerly the Graham Air Force Station, through our surplus property utilization program. Most of the personal property for the operation of this facility was conveyed with the real estate.

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 the surplus property 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.

In 1966, the State of Ohio received the former Veterans Administration Hospital at Broadview Heights, near Columbus. Now known as the Broadview Center for the Mentally Retarded, in-patient service was begun in 1968. During the year, 580 persons applied for service. Of this number, 115 were admitted to the hospital unit. It is expected that the Center will have a capacity for 250 inpatients, in addition to its large out-patient load, with future expansion to 600.

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 the mentally retarded. The State of Kansas has renovated the Winter Veterans Administration Hospital, comprising 225 acres and 195 buildings, for the treatment and care of some 300 to 400 mentally retarded children.

Smaller areas, such as former Post Office buildings and sites and 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 Federal property, both large and small, no longer required for Government use, which are continuing to serve the country in the care of its mentally retarded.

Through June 30, 1969, 5,035 acres of land and 765 buildings have been transferred to institutions for use in programs serving the mentally retarded. These properties originally cost the Government \$40,580,913, and had a fair market value of \$16,119,001 at time of transfer.

APPENDIX A

U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Obligations for Mental Retardation Activities

Fiscal Years 1969-1971
(Thousands of Dollars)

ACTIVITY	1969	1970 (Revised Budget Estimate)	1971 Budget Estimate
<u>HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION</u>			
<u>Services</u>			
Comprehensive Health Planning and Services	2,612	525	-0-
Maternal and Child Health and Welfare	12,990	12,990	12,990
<u>Total, Services</u>	15,602	13,515	12,990
<u>Training</u>			
Mental Health Research and Services	447	441	438
Comprehensive Health Planning and Services	1,592	50	-0-
Maternal and Child Health and Welfare	14,765	14,765	16,965
<u>Total, Training</u>	16,804	15,256	17,403
<u>Research</u>			
Mental Health Research and Services	600	600	-0-
St. Elizabeth's Hospital	24	-0-	-0-
National Health Statistics	6	-0-	-0-
Maternal and Child Health and Welfare	2,000	2,000	1,900
<u>Total, Research</u>	2,630	2,600	1,900
<u>Construction</u>			
Hill-Burton	352	-0-	-0-
<u>Total, Construction</u>	352	-0-	-0-
<u>Other</u>			
Mental Health Research and Services (Abstracts)	52	-0-	-0-
<u>Total, Other</u>	52	-0-	-0-
<u>TOTAL, HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION</u>	35,440	31,371	32,293

ACTIVITY	1969	1970 (Revised Budget Estimate)	1971 Budget Estimate
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SOCIAL SECURITY ADMINISTRATIONIncome Maintenance

Estimated Benefit Payments from Trust Funds	127,400	138,500	148,900
Trust Fund Obligations In- Curred to Adjudicate Claims of Beneficiaries	1,800	2,000	2,100
<u>Total, Income Maintenance</u>	<u>129,200</u>	<u>140,500</u>	<u>151,000</u>

TOTAL, SOCIAL SECURITY ADMINISTRATION	129,200	140,500	151,000
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NATIONAL INSTITUTES OF HEALTHTraining

Neurology and Stroke Activities	10,000	9,000*	8,500
Child Health and Human Development	3,066	2,754	2,709
<u>Total, Training</u>	<u>13,066</u>	<u>11,754</u>	<u>11,209</u>

Research

Neurology and Stroke Activities	11,950	11,153	11,000
Child Health and Human Development	12,542	12,021	14,271
<u>Total, Research</u>	<u>24,492</u>	<u>23,174</u>	<u>25,271</u>

TOTAL, NATIONAL INSTITUTES OF HEALTH	37,558	34,928	36,480
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SOCIAL AND REHABILITATION SERVICEServicesRehabilitation Services and
Facilities

Basic State Grants	43,817	64,262	72,338
Innovation	127	127	127
Rehabilitation Service Project	3,808	3,708	4,326
Services for the Mentally Retarded	15,448	19,725	19,990

Total, Rehabilitation Services and Facilities	63,200	87,822	96,781
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Medical Assistance
(Title XIX 1/)

	75,000	90,000	105,000
Total, Medical Assistance	75,000	90,000	105,000

Total, Services to or for the
Mentally Retarded

	138,200	177,822	201,781
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*Includes both mental retardation grants and grants in
other programs relevant to mental retardation.

ACTIVITY	1969	1970 (Revised Budget Estimate)	1971 Budget Estimate
<u>Training of Professional and Supportive Personnel</u>			
Research and Training	1,532	1,396	1,396
Total, Research and Training	1,532	1,396	1,396
Rehabilitation Services and Facilities Services for the Mentally Retarded	1,882	4,187	4,800
Total, Rehabilitation Services and Facilities	1,882	4,187	4,800
Grants to States for Public Assistance - Child Welfare Training	100	100	100
Total, Public Assistance	100	100	100
<u>Total, Training of Pro- fessional and Supportive Personnel</u>	3,514	5,683	6,296
<u>Research</u>			
Research and Training			
Research and Demonstration	984	1,116	1,116
Special Rehabilitation Centers	800	855	900
Social and Rehabilitation Activities Overseas (Special Foreign Currency Program)	600	700	800
Total, Research and Training	2,384	2,671	2,816
Rehabilitation Services and Facilities - Services for the Mentally Retarded	126	113	-0-
Total, Rehabilitation Services and Facilities	126	113	-0-
<u>Total, Research</u>	2,510	2,784	2,816
<u>Construction</u>			
Rehabilitation Services and Facilities			
Facilities for the Mentally Retarded	23,869	23,405	8,000
Vocational Rehabilitation Services	846	123	121
Total, Rehabilitation Services and Facilities	24,715	23,528	8,121
<u>Total, Construction</u>	24,715	23,528	8,121

ACTIVITY	1969	1970 (Revised Budget Estimate)	1971 Budget Estimate
<u>Income Maintenance</u>			
<u>Public Assistance 2/</u>			
Grants to States	65,000	75,000	86,000
<u>Total, Income Maintenance</u>	65,000	75,000	86,000
TOTAL, SOCIAL AND REHABILITATION SERVICE	233,939	284,817	305,014
<u>OFFICE OF EDUCATION</u>			
<u>Services to or for the</u>			
<u>Mentally Retarded</u>			
Elementary and Secondary Education Activities (ESEA)			
Title I	26,300	31,300	35,600
Title III	5,218	3,653	4,905
Title VI 3/	15,555	16,000	16,500
Vocational Education Activities			
Vocational Education Act (Part B)	-0-	11,500	11,500
Early Education of the Handicapped	185	570	800
<u>Total, Services to or for the</u>			
<u>Mentally Retarded</u>	47,258	63,023	69,305
<u>Training</u>			
Educational Improvement for the Handicapped	10,000	10,000	10,500
Educational Professions Development	796	860	1,004
<u>Total, Training</u>	10,796	10,860	11,504
<u>Research</u>			
Cooperative Research Act P.L. 85-531 (as amended)	13	-0-	-0-
National Defense Education Act (Title VII)	-0-	-0-	-0-
Vocational Education Activities P.L. 88-120	-0-	-0-	-0-
Educational Improvement for the Handicapped	2,000	1,150	733
<u>Total, Research</u>	2,013	1,150	733

ACTIVITY	1969	1970 (Revised Budget Estimate)	1971 Budget Estimate
<u>Other</u>			
Libraries Services and Construction Act (Title IV)	15	15	15
University Community Services P.L. 89-329 (Title I)	75	75	-0-
<u>Total, Other</u>	90	90	15
TOTAL, OFFICE OF EDUCATION	60,157	75,123	81,557
<u>OFFICE OF THE SECRETARY</u>			
Secretary's Committee on Mental Retardation	(120)	(111)	(115)
President's Committee on Mental Retardation	580	580	626
TOTAL, OFFICE OF THE SECRETARY	580	580	626
TOTAL, SERVICES AND GRANTS	302,674	351,819	369,970
TOTAL, INCOME MAINTENANCE	194,200	215,500	237,000
GRAND TOTAL, ALL FUNDS	496,874	567,319	606,970

Footnotes

- 1/ These expenditures are based on present experience with six States claiming an average of approximately \$5 million per State for a full year for the care of the retarded in State institutions. Fifteen States for 1969 and twenty States for 1970 are estimated in the amounts shown. There is presently no method available for estimating Title XIX payments for the care of the retarded outside of State institutions.
- 2/ 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 constant percentage of total payments under this part of the program.
- 3/ Includes 50% of funds appropriated for Title VI ESEA; specific estimates of obligations for mental retardation activities are unobtainable.
- 4/ Shown as non-add items since funds derived from funds available to various agencies for mental retardation activities.

Mr. JARMAN. Thank you very much, Mr. Black.

Would you provide the subcommittee with specific recommendations for the fiscal years, 1971, 1972, and 1973?

Mr. BLACK. Yes, Mr. Chairman. I think we could do that.

As indicated in my testimony, our bill does call for such sums as may be necessary.

As we have done on other occasions, however, we can give you some figures which represent our program estimates and our hopes of finding levels.

Now, this is with the understanding that this does not constitute a commitment on the part of the Department to either request or budget such funds, because we cannot look that far ahead.

But, for the committee's guidance, I think we can give you some figures which would be useful.

For the next fiscal year, 1971, the budget requests for the programs administered by the Division of Mental Retardation is \$32,790,000. That includes all of the programs under this Mental Retardation Facilities Constitution Act—staffing, construction and university-affiliated facilities. It includes also the hospital improvement program and the rehabilitation services program.

Mr. JARMAN. Am I correct in understanding that in the 1971 budget there is no money requested for new construction?

Mr. BLACK. No money requested in the 1971 budget, Mr. Chairman, for university-affiliated facilities. The request in the 1971 budget for community facilities construction is \$8 million; for staffing, it is about \$11 million, for a total of \$19 million. So, there are those two, and there are none for university-affiliated facilities.

Then, we have also requested for the hospital improvement program, \$9 million, and for rehabilitation services, \$4.5 million, bringing us to this total requested that I gave you of \$32,790,000.

Mr. JARMAN. For 1971?

Mr. BLACK. For 1971.

For 1972, based upon our preliminary planning, we believe that a funding level of \$40 million would be possible. Looking ahead to 1973, it is a little more difficult the further we move ahead to make an estimate, but we would hope again to increase the funding level perhaps to as much as \$60 million. But, again, I want to emphasize that these are estimates of funding levels which we hope to reach, and, obviously, whether we can request or budget those amounts will all depend on a number of other considerations at the time.

I think that it is fair to say that this administration, certainly will not be requesting more than these figures, and, as I indicated in my prepared testimony, we cannot envisage the levels of funding that are proposed in some of the other legislation.

Mr. JARMAN. Well, in your statement, you referred to a broad-gaged review of HEW programs in the area of mental retardation as a basis for decision on needed expenditures.

Does the Department have a timetable on that?

Can you estimate when that review will have been completed?

Mr. BLACK. I would hesitate to give you a firm timetable on that, Mr. Chairman.

Our office of planning and evaluation is undertaking this review of all of our MR programs. Meanwhile, there are some other reviews that have been going on. There has been a separate study of the pro-

gram on university-affiliated facilities which, I think, is nearing completion. That one, and any decision springing from it, should be available fairly soon.

As for the larger review, I think I could say we would be several months away from completion of that. But there is, as I indicated here, and as I think you will see when you study this report we gave to the Appropriations Committee, a proliferation of these programs in the Department which have developed over the years. We have been to this committee before on some other matters which as a new administration coming in, wanted to review and are reviewing. This one is near the top of our list in that area.

Mr. JARMAN. Do you have a copy of H.R. 15160?

Mr. BLACK. Yes, sir.

Mr. JARMAN. On page 2, section 102(a) dealing with the authorization of grants, I have some doubts in my own mind as to what this covers. Is this just for staffing?

Mr. BLACK. Well, this is for operation, Mr. Chairman. This covers the previous commitments that we have made on that part of the program.

Mr. JARMAN. And can you give us cost figures on this?

Mr. BLACK. Yes, sir. Our estimate is that the previous commitments would take about \$10 million of the total \$32 million or \$33 million we were talking about.

Mr. JARMAN. About a third?

Mr. BLACK. Yes, sir.

Mr. JARMAN. About \$10 million?

Mr. BLACK. Yes, sir.

Mr. JARMAN. All right.

Thank you.

Mr. ROGERS?

Mr. ROGERS. Thank you very much.

Mr. Secretary, it is good to see you and your associates here today. What preventive services are you carrying out under this legislation in the Department?

Mr. BLACK. In the report here, Mr. Rogers, a number of these are specified. I can ask Mr. Newman or Dr. Jaslow to comment on that, and I would say that beyond the immediate programs under their supervision there are a couple of others that we are concentrating on. Of course, one this committee is familiar with is the Rubella program, and another is family planning.

Again, this committee is familiar with our activities in that respect.

Mr. ROGERS. What is being done in family planning as far as prevention of mental retardation is concerned?

Mr. BLACK. As you know, we are setting up a strengthened and expanded center for research and delivery of family-planning services.

Mr. ROGERS. What is the extent of that?

I am not sure we are completely familiar with it.

Mr. BLACK. Well, this is part of our effort to carry out the President's commitment to reach in the next few years 5 million women who are not getting family-planning services.

Most of these, as you can imagine, are women in the lower income groups, and when we find that the incidence of retardation is so much

higher in these groups, why, we look upon our family-planning activities which are going—

Mr. ROGERS. What's being done? You say it is a center?

Mr. BLACK. Yes. You know, we have one center in NIH for basic research and we have another center at HSMHA.

Mr. ROGERS. Where?

Mr. BLACK. HSMHA, which is concentrating on the delivery of family-planning services. Both of these are being coordinated now under the leadership of our new Deputy Assistant Secretary for Population, Family Planning Affairs, Dr. Louis Hellman.

Mr. ROGERS. And what is the budget for these activities?

Mr. BLACK. I am sorry, Mr. Rogers, I will have to provide that for the record.

Mr. ROGERS. Do either of your associates know?

Mr. NEWMAN. This is not in our neck of the woods.

Mr. ROGERS. All right.

If you will furnish that for the record, that will be fine.

(The following information was received for the record:)

Family Planning Research and Service Activities in the Department of Health, Education, and Welfare—Fiscal Year 1971

HSMHA National Center for Family Planning Services.....	\$33, 515, 000
NIH National Institute of Child Health and Human Development (including the National Center for Family Planning Research) ..	28, 341, 000
Total	61, 856, 000

Mr. ROGERS. As to preventive services, what is being done?

Dr. JASLOW. In this particular program?

Mr. ROGERS. Yes.

Dr. JASLOW. Sir, primarily—

Mr. ROGERS. For mentally retarded, what is being done to prevent it?

Dr. JASLOW. Throughout the Department?

Mr. ROGERS. Yes.

(The following information was received for the record:)

PREVENTIVE SERVICES

Preventive services are defined as services which are rendered as a part of programs designed to reduce the incidence of mental retardation. The major programs in this area are administered by the Health Services and Mental Health Administration. The Food and Drug Administration is also concerned with preventing mental retardation that might follow the use or misuse of drugs or hazardous substances. Some examples of preventive services are:

1. The National Communicable Disease Center is providing the leadership in the national rubella control program. Working through 68 grant-assisted State and local health department projects which serve over 93 percent of the nation's population, the Immunization Branch has collaborated with health agencies in providing (1) well-trained qualified personnel who engage in (a) planning, organizing, and promoting activities in connection with rubella immunization programs, (b) intensive public informational, educational, and motivational activities, (c) maintaining intensive epidemiologic and laboratory surveillance, (d) immunization level surveillance and (e) use of jet injector and other immunizing equipment, and (2) rubella vaccine to be used in protecting susceptible children.

2. The National Communicable Disease Center through its measles immunization program has all but eliminated this once common childhood disease. The number of cases now being reported is the lowest since measles reporting began early in the century (1912). From 1963, when measles virus vaccine became available, through 1968, 33.7 million doses of vaccine have been distributed in the

United States. Due to the near eradication of this disease the problems and measles-associated encephalitis, mental retardation, and deaths are diminishing.

3. Maternity and Infant Care Projects support programs which provide necessary health care to prospective mothers in high risk populations. By December 1969, fifty-three such projects were in operation. Grants which support screening programs for phenylketonuria (PKU) and other metabolic diseases also are awarded by the Maternal and Child Health Service. As of December 1968, forty-three States had enacted laws related to PKU, most of them making screening for this disorder mandatory.

4. Interest is also increasing in metabolic diseases other than PKU that lead to mental retardation. The MCHS is continuing to support 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.

5. Increasing attention is being paid to lead poisoning. Despite present-day manufacture and use of lead-free paint, many children become mentally retarded or suffer other damage from ingestion of chips of lead-containing paint from walls and woodwork in old, dilapidated housing. A publication, "Lead Poisoning in Children," addressed to public health workers, has been prepared, suggesting a program of prevention, casefinding, follow-up of cases, and other measures to cope with this problem. Some of the Children and Youth projects funded by Maternal and Child Health have had a special interest in finding and treating children with lead poisoning.

6. FDA's Bureau of Medicine monitors the investigational use of new drugs in early testing phases. Animal experimentation is required to prove a new drug safe and effective before that drug may be tested on human beings. FDA expects investigators to set up metabolic methodology on new entities, at least to attempt to develop functional toxicology and biochemical toxicology, relating experiences of one species to those of another, eventually to experiences of man. FDA also is concerned with the treatment of mental retardation. Special diets and drugs may or may not be effective. Regulatory action is taken against drugs or devices that are represented to be useful in the prevention or treatment of mental retardation but in fact have no such beneficial effect. Surveillance by FDA covers any untoward effect of chemical entities used in foods, drugs, cosmetics or household chemicals. These data are acquired in close liaison with many hospitals, with the American Medical Association, the World Health Organization, the pharmaceutical industry, and with other health, education, and welfare agencies. This information is catalogued, retrieved, and evaluated by means of an advanced data processing system.

Dr. JASLOW. In our particular program in the Division of Mental Retardation our efforts are more geared to secondary prevention, early identification of handicaps that can lead to greater degrees of mental retardation, or secondary handicaps. The Office of Education, certainly, is moving into earlier education of children and into specialized education which, in many respects, can lead to amelioration or correction of functional mental retardation.

Mr. ROGERS. What would you say is the budget being devoted for that specifically?

Mr. NEWMAN. On the broad area of prevention, Mr. Rogers?

Mr. ROGERS. Yes—If you can, furnish that for the record. If you can furnish that, that would be fine.

Now, specifically, on your program, what are you doing now for the prevention?

Dr. JASLOW. For prevention?

Mr. ROGERS. Yes.

Dr. JASLOW. Our program is geared more for the care and amelioration of the handicaps of those already identified, but there are some in the program who are misdiagnosed, or misidentified rather, due to the fact that these frequently are multiply handicapped and they are difficult to diagnose. There are multiple handicaps, and sometimes, in spite of all of our testing mechanisms, one needs really a therapeutic program to determine the possibility that really there is no intellectual deficit.

Mr. ROGERS. How much of the funding would you say goes for prevention?

Dr. JASLOW. That is a difficult thing to say, sir, since with the improvement of identification that is going on, we are salvaging or finding fewer who are misdiagnosed than before. I think in the small percentage of individuals who have defects of a genetic nature where one would be aware of the need for genetic counseling, that one could consider that part of the preventive effort is there, but basically, the Division of Mental Retardation programs are much more concerned with secondary prevention; in other words, reducing the dependence of the individual.

Mr. ROGERS. In other words, once the disease is upon you, this is where we are concentrating our efforts? Is that what you are telling me?

Dr. JASLOW. For the most part, except in the—

Mr. ROGERS. Vaccination program?

Mr. JASLOW. Yes, and the facilities that provide for training and for diagnosis, of course are not geared specifically to those that are already identified. Part of the training and services relate to diagnostic problems.

Mr. ROGERS. Yes.

Now, we took up some legislation which was the communicable disease and immunization program which the Department did not support, and I realize you are spending some funds for the Rubella measles program. What is the extent of that?

Mr. BLACK. I have those figures here. Let me get them for you: \$9.6 million in the 1969 supplemental, and \$16 million for the project support and vaccine in 1970 for a total of \$25.6 million used for State and local support for programs and vaccines. This will provide all that is necessary for program support through June 30, 1971.

Mr. ROGERS. Now, do you know how many children that covers?

Mr. BLACK. I do not.

Mr. ROGERS. Eight million to 10 million, I understand from Mr. Lewis. And do you know how many children, as estimated by Mr. Lewis, should be covered?

Mr. BLACK. No, sir; I do not.

Mr. ROGERS. 45 million.

Now, do you know what it costs in a lifetime for care for the children who have gotten the disease, that were affected in the 1964 epidemic?

It is estimated that the cost to take care of those 20,000 to 30,000 born with Rubella defects in 1964 is \$2.6 billion.

Think of that.

Now, when we start talking about inflation, this is where, I think, the Department needs to re-look at its whole approach and somehow

get its message through to the Budget and to the White House and this is where, I think, that all of us, perhaps, have been deficient in not selling the health program. We talk about it, and we say: "Oh, we have got too many fiscal restraints because of inflation," but we do not relate what happens to inflation if we do not do these things. Now, if we do not have a vaccination program, if we do not have mentally retarded programs, what happens is that somebody has to spend this money to take care, and it is the people who are having to pay it out—and it is not the Government; it is the people, and they are the ones affected by inflation, and this \$2.6 billion, which could be prevented because we have the knowledge and yet we are not using it.

Now, it seems to me that we had better recast our whole thinking in taking care of the health of people if we really want to help with inflation.

I do not know of anything that is more destructive to one's own budget than to have to pay for rising health costs, and by paying a little bit to get a vaccination to prevent it there is no telling what we could do with inflation. In fact, I think the highest inflationary factor in our society today is medical costs.

Well, how are we going to stop it?

By having prevention programs and care programs that will cut down.

Mr. BLACK. I think we agree with you on that, Mr. Rogers.

Mr. ROGERS. But we have not sold that yet. This is the point I am making, Mr. Secretary.

Mr. BLACK. Apparently, there is a difference of opinion between the Department and the committee—or at least you—as to whether we are doing all in the Rubella program in the coming year that could be done. Our understanding is that we are giving it all of the necessary program support through June 30, 1971. As I pointed out earlier here, over \$25 million has already been awarded to State and local health departments by HEW, and additional funds are coming from the State and local health departments, themselves. By this fall, as I understand it, at least half of the target group will have been vaccinated.

Mr. ROGERS. 8 million to 10 million first, second and third graders, and they are not covering the rest of the grades, which they could. This is the point.

Mr. BLACK. The Department's estimates are that by June of this year, 12 million children will have immunization, and that by fall one-half of the target population of 40 million children will be reached.

But, apart from this, certainly, we agree with your basic point that prevention is something we should be concentrating on. As I have pointed out in my prepared statement, the cost of the Rubella epidemic of 1964 was immense, and money that we can invest through this prevention is money that is well spent.

We feel that these other related efforts, such as the family-planning effort, will have a very significant impact here. I would point out another thing which we also think is going to have an impact in this area is the family-assistance program that we have proposed. Again, when you go back into this basic figure that the President's Committee on mental Retardation has developed, that 75 percent of all mental retardation is in poverty areas, it seems to us everything you can do in these areas to lift people out of this poverty cycle and to make

family-planning services available to them is helping in the prevention of mental retardation. And, you know, the Department has made——

Mr. ROGERS. This, I understand, and I think it is commendable, and I would agree that all of these things help.

But where we have specific scientific knowledge that we can prevent things and we are not doing it to the extent that we can, then I question whether we are really getting in and fighting inflation or anything else. That is the point I am making, and I understand that all of these other things do help and that they are needed.

But, prevention? I just do not think we are doing enough there. We could do more. We ought to cover 45 million, and, according to the testimony before our committee, this is not being done. It will only cover 8 to 10 million.

Now, are there any other preventive services?

What about PKU?

How much money is being used to get into this?

Any testing, any program, any organized effort?

Dr. JASLOW. Yes. Most States have a preventive program or a testing program to identify individuals with PKU.

Mr. ROGERS. To what extent?

Dr. JASLOW. I believe, at the moment, over 35 States have this program.

Mr. ROGERS. Why should not all 50 of them have it?

This is something that can prevent.

Dr. JASLOW. It may be more than that at this time.

Mr. ROGERS. How much money are we devoting to this?

Has the Department got a figure or a plan? Are we pushing it?

Mr. BLACK. Yes, we are pushing it.

Mr. Rogers, on page 11 of the report of the Secretary's committee, you will find a discussion of what is being done in this area of PKU. It points out that we have been encouraging all of the States to move on this.

Mr. ROGERS. Well, encouraging them how?

Mr. BLACK. In December, 1969, 43 States had such laws.

As to how much we are budgeting and expending on that, again the figures that we have are not broken down.

Mr. ROGERS. Would you give us that for the record?

Mr. BLACK. We certainly can.

(The following information was received for the record:)

PKU TESTING FUNDS

The amount of funds spent for PKU testing is not available. States include screening and testing for PKU in their State plans, as one of their preventive services related to mental retardation. It is not possible to separate funds spent for PKU screening and testing from other services provided by the States' programs.

Mr. ROGERS. I think that will be helpful.

I have a feeling that we are not doing what we could do there, too.

Now, what are we really doing in training personnel?

What funds are being devoted to training personnel to deal with these people?

How many people have we trained?

Mr. BLACK. Mr. Newman?

Mr. NEWMAN. Do you want us to speak to the numbers that have been trained in the program?

Mr. ROGERS. If you do not have those figures, it will be all right to furnish them for the record.

Could you give me an estimate, any idea of about what we have done?

Dr. JASLOW. Well, training is supported through different parts of the program. In the inservice training program, we are training about 15,000 people a year.

Mr. ROGERS. 15,000 a year?

Dr. JASLOW. In the university-affiliated program to date, I think there are, so far, about 6,000 a year trained.

Mr. ROGERS. Now, these are the ones that will teach the others in the university-affiliated program, the 6,000, or is this just refresher courses, or are these 2-week courses, 6 months, or a year?

Dr. JASLOW. These, for the most part, are people who are getting sufficient training to either teach or to provide treatment or services to the retarded.

Mr. ROGERS. Now, I see. Now, what is the time element involved in that program?

I presume it varies?

Dr. JASLOW. Yes, it does vary considerably.

Mr. ROGERS. What is the least amount in the university-affiliated training program?

Dr. JASLOW. There are some very short courses, but they are usually not considered in this total that I gave you.

Mr. ROGERS. Two-week courses?

Dr. JASLOW. There are 2-week courses and what we call "exposure."

Mr. ROGERS. Of this 6,000?

Dr. JASLOW. They receive a minimum of about 30 days to 90 days.

Mr. ROGERS. A minimum. And what is the most?

Dr. JASLOW. There are people in training, in the universities who would go as long as 3 to 5 years, for example, in the area of the Ph.D.

Mr. ROGERS. How many would that be?

It is not too large, I would assume.

Dr. JASLOW. Not too large.

Mr. ROGERS. Well, let us have that for the record, please.

(The following information was received for the record:)

UNIVERSITY AFFILIATED TRAINING CENTERS IN MENTAL RETARDATION

Of the approximately 6,000 persons receiving interdisciplinary training in University Affiliated facilities, about 1,000 are receiving long term specialized training at the post graduate level, a large percentage of these at the doctoral and post doctoral level. This group represents the teachers of future mental retardation specialists and future administrators and practitioners serving the retarded. The remaining 5,000 trainees receive interdisciplinary training ranging from several weeks to several months. This group represents pre and post graduate level students of a variety of disciplines. The interdisciplinary training they receive is designed to increase their effectiveness in serving the retarded. In some cases this leads to enrollment in long term specialist training toward an advanced degree.

Records of trainee placement from eight fully or partially operational UAF's indicate that well over 90 percent of the resident trainees (those who received over 500 hours of training) entered the field of mental retardation or a closely allied career. At least 30 trainees from this group were hired by UAF's to fill vacant staff positions, while the remainder went into service positions.

It is estimated that when all approved centers are fully operational, over 10,000 persons will be receiving training annually. About 25 to 30 percent of this number will compose the resident or long term trainee population.

Mr. ROGERS. Now, how much money is being spent on training as such?

Dr. JASLOW. Again, I could only give you the figures by program breakdown.

Mr. ROGERS. Just rough, and later furnish the correct figures for the record.

Dr. JASLOW. In the hospital inservice training programs, it is about \$2 million—\$2.3 million. In the university affiliated programs, I believe the Children's Bureau is spending about \$9 million, and the Office of Education, and Vocational Rehabilitation, in the Rehabilitation Services Administration are probably funding another, maybe, \$1.5 million to \$2 million.

Mr. ROGERS. \$2 million?

The 15,000 figure that you used for inservice training is in retardation centers?

Dr. JASLOW. Primarily, the public institution.

Mr. ROGERS. Not the university?

Dr. JASLOW. No, although there are some universities providing this program for institutions.

Mr. ROGERS. I would like a program of where these people are trained, and so forth. I presume what you are talking about is you get volunteers to come in and train them, to try to be helpful. Is this part of it?

Dr. JASLOW. That would be part of it, but I do not think that they are included in the figures.

Mr. ROGERS. It is not?

These are people who will be used in the center?

Dr. JASLOW. Right.

Mr. ROGERS. What is the time of training? Just while they are working; is that what you mean?

Dr. JASLOW. Yes, inservice training varies from several weeks to several months. It may be carried out over a period of time.

Mr. ROGERS. If you could, let us have it for the record.

(The following information was received for the record:)

MENTAL RETARDATION HOSPITAL INSERVICE TRAINING PROGRAM

The Hospital Inservice Training Grant Program, also administered by the Division of Mental Retardation, provides grant to State Residential Institutions for the Mentally Retarded for new and/or expanded training of supportive, technical and professional personnel.

The major purposes of the Mental Retardation Hospital Inservice Training program are: (1) to increase on a continuing basis the effectiveness of available staff in residential facilities for the mentally retarded; (2) to provide effective services to the mentally retarded by improving the quality of training of the personnel. Inservice training is broadly defined to include any or all of the following:

a. Orientation and initial on-the-job training for attendant level employees;

b. Refresher, continuation, and other special job-related training courses for employees.

In addition to the above, a portion of the grant may be utilized for special training for staff with inservice training responsibilities; and special training for staff with management responsibilities.

The basic inservice training of attendant personnel ranges from a minimum of 65 hours to a maximum of 480 hours. The average training time is 182 hours including classroom and supervised practice types of training within the institutions.

Institutions are free to develop their inservice training programs in any way suited to their immediate and long range needs, within the stated policies.

A number of institutions have effectively utilized the University Affiliated Centers as sources for curriculum guidance, training of inservice trainers and as resources for continuing education for professional personnel. Examples of States in which institutions have such arrangements include Massachusetts, Kansas, Tennessee, Washington, and Wisconsin.

Mr. ROGERS. Now, what research are you doing? And what is your budget? And what is being accomplished?

Mr. NEWMAN. Right now, Mr. Rogers, for the small research item we had in the Division of Mental Retardation, this year we have \$126,000.

Mr. ROGERS. For research?

Mr. NEWMAN. In the Division of Mental Retardation, specifically for retardation, that no longer is a budget item, sir.

Mr. ROGERS. Research is no longer a budget item?

Mr. NEWMAN. In this division, that is correct. That does not mean that the Department of Health, Education, and Welfare is not expending considerable amounts of money in research related to mental retardation.

Mr. ROGERS. What is being spent?

Mr. BLACK. Again, Mr. Rogers, that figure we will have to give you for the record.

(The following information was received for the record:)

MENTAL RETARDATION RESEARCH IN THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

[In thousands of dollars]

	1969	1970	1971
Health Services and Mental Health Administration.....	2,630	2,600	1,900
National Institutes of Health.....	24,492	23,174	25,271
Social and Rehabilitation Service.....	2,510	2,784	2,816
Office of Education.....	2,013	1,150	733
Total.....	31,645	29,708	30,720

Mr. BLACK. The breakdown we have from the Secretary's committee, which is the most comprehensive part of this, simply does not break it down, I think, in a way that would answer all of your questions. If you will notice near the back there, next to the last page, there is a total figure for research.

Mr. ROGERS. How much is that?

Mr. BLACK. And this, you will see, is broken down by different offices, and I would prefer to have our budget people give you a figure on that.

Mr. ROGERS. Well, if you could break it down by the offices—what is the figure there, given in the chart?

Mr. BLACK. Starting at appendix A, you will see the research for the Health Services and Mental Health Administration, and this is the 1971 budget estimate of \$1,900,000.

Mr. ROGERS. About \$2 million.

Mr. BLACK. Yes; research in NIH, 1971, would be \$25 million.

Mr. ROGERS. For what?

Mr. NEWMAN. National Institutes of Health.

Mr. ROGERS. Now, is that all devoted to retardation?

Mr. BLACK. Yes, sir; this is in the area of retardation.

Mr. ROGERS. \$25 million?

Mr. BLACK. \$25 million. And some of this I should explain, Mr. Rogers, is a part of larger programs, but these are the parts of those programs devoted to mental retardation. This is the breakdown that we have got on the \$600 million, and it was arrived at in that way.

Mr. ROGERS. I did not know that we were really spending \$600 million for the retarded.

I did not realize that we were.

Mr. BLACK. Well, I think that comes as a surprise to a number of people. I think that you will find that the report documents it rather well.

Mr. ROGERS. It is rather a broad coverage, is it not?

For instance, medicaid. How much comes from medicaid, for instance?

Mr. BLACK. I do not believe we are covering medicaid.

Mr. ROGERS. I understood you were.

Mr. BLACK. Some income maintenance programs: Social security, aid to the disabled.

Mr. ROGERS. If you could break those down, as to where those programs' funds go?

Mr. NEWMAN. Look at the total in the whole social and rehabilitation area, and we have a total of about \$2,800,000 in research and over \$300 million going into other activities. This includes over \$100 million in medicaid funds.

Mr. ROGERS. \$2,800,000. And I would like a breakdown of the \$25 million figure to see what that has done.

(The following information was received for the record:)

NIH RESEARCH ON MENTAL RETARDATION

NATIONAL INSTITUTE OF CHILD HEALTH AND HUMAN DEVELOPMENT (NICHD)—
\$14,271,000

National Institutes of Health supported research covers nearly the whole spectrum of biological and clinical research disciplines and a great many of the behavioral ones as well. In recognition of the complexity of the disease entities involved efforts have been made to stimulate multifaceted and interdisciplinary attacks on the problem. The appropriate support mechanism for such research is the program project grant and some success is indicated by the increase in the number of such awards from 16 in fiscal year 1968 to 21 in FY 1969. In all, 92 research grants (including program grants) and 4 contracts are currently active. Of these, approximately 70 percent of the research grants are in biomedical research and 30 percent in the behavioral research areas in terms of dollar amount. In contracts, 3 are biomedical and 1 is behavioral. In dollar amounts, 88 percent of contract expenditures go toward biomedical research and 12 percent toward behavioral research.

A large fraction of current biomedical research support is devoted to cytogenetic and tissue culture investigation of genetic defects including inborn errors of metabolism and mongolism. In the past year one investigator, supported by NICHD, has expanded and extended the knowledge gained from this research to the point where he (as well as others) is able to test cells and amniotic fluid obtained by transabdominal amniocentesis at 14 weeks of pregnancy to determine whether the infant will be normal with respect to many of the diseases which can result in mental retardation. It is expected that, as this technique becomes refined and more easily employed, in utero management

such as enzyme induction through surgical implantation, drug administration, and others will be developed. This technique, coupled with therapeutic abortion, where indicated, will result in a substantial reduction in the incidence of mental retardation.

The role of malnutrition in etiology of mental retardation is receiving increased attention by the NICHD. One investigator supported by NICHD has reported results of a longitudinal study which contains convincing evidence indicating that malnutrition occurring early in infancy can result in reduced intellectual capacity and ability to adapt to the environment. Additional studies have been mounted in this country and abroad and are currently receiving support from the Institute. Due to the difficulties of separating other environmental effects such as chronic infection, lack of social stimulation, etc., from those of malnutrition these studies are difficult to perform and their results must be interpreted with great caution. The available evidence from both animal and human studies dictates, however, that more knowledge be gained for a full understanding of the role of malnutrition in relation to intellectual development.

A contract for the investigation of the effects of improving the maternal diet during pregnancy has been let in a large urban poverty area in order to measure the effects of a more adequate maternal diet on the developing child. A study already in progress in a southern rural area to examine the effects of maternal dietary supplementation on offspring growth has been expanded this year to include measures of intellectual and behavioral development in the children. A study in Guatemala, supported jointly by NICHD and INCAP, has reached the stage of definitive data collection after a necessary long period of developing and testing methods and measurement scales of behavior. Preliminary data indicate that early severe protein-calorie deficiency results in deficits in behavior clustering in certain psychological areas. Similar research programs in Mexico and Chile are supported by the Institute.

Seven of the 12 mental retardation research centers authorized for construction under Part A, Public Law 88-164 were completed and operational in fiscal year 1970. The completed centers are located at the University of Washington, Seattle, Washington; George Peabody College for Teachers, Nashville, Tennessee; Albert Einstein College of Medicine, Bronx, New York; University of California at Los Angeles, Los Angeles, California; University of Colorado Medical Center, Denver, Colorado; Cincinnati Children's Hospital, Cincinnati, Ohio; and the University of Chicago, Chicago, Illinois. Centers at Children's Hospital Medical Center, Boston, Massachusetts; Fernald State School, Waltham, Massachusetts; University of Kansas, Lawrence, Kansas; and the University of North Carolina, Chapel Hill, North Carolina are expected to be completed in fiscal year 1971. The center at the University of Wisconsin, Madison, Wisconsin is scheduled for completion by July, 1972.

At the Federal level the NICHD has primary responsibility for assisting center administrations with the development and operation of the centers' programs of research and research training in the field of mental retardation and related aspects of human development. When fully operational it is anticipated that the centers will carry the major research thrust of our nation's efforts to combat mental retardation.

The research activities of the centers are many and varied. Several of the centers are working on the problem of mental retardation associated with depriving life circumstances. The center at Kansas is making notable progress in methods utilizing local people, especially mothers, in creating or improving the conditions under which the intellectual development of children is stimulated. Methods of constructive intervention to prevent or minimize poverty-linked retardation are under way and others are being planned at the Peabody Center. Studies with the same aims are under way or planned at the University of North Carolina where ways of preventing retardation in the disadvantaged through the use of psycho-social intervention are underway. The staff of the University of Wisconsin Center is currently deeply concerned with rehabilitative methods as well as biomedical research on metabolic disorders such as phenylketonuria. At the University of Washington Center the staff is planning an interdisciplinary, longitudinal research program to relate medical, biochemical, electrophysiological and other events during pregnancy with the neurological sequelae observed in infants and children. This will make possible elucidation of the role of events or processes occurring during gestation, birth and the neonatal period, which can result in mental retardation, and, hopefully, will assist in finding preventive or therapeutic measures.

The National Institute of Neurological Diseases and Stroke sponsors research in mental retardation when mental retardation appears as a symptom, complication or sequela of some disease of the central nervous system. Consequently, a large number of research projects supported by NINDS can be said to be relevant to mental retardation research, although the interest of the scientist may be in the study of some particular phase of disease rather than in mental retardation directly. The research projects involved use nearly all of the scientific disciplines to some degree.

One of the Institute's major efforts which has great interest for mental retardation research is a collaborative project with 14 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 through the first year of school.

This program was started in 1959. The gathering of data has been completed for pregnancies, deliveries and on all children through the age of one year. About 30 percent of these children are now age seven, and are completing their examination schedule. Concurrent evaluations indicate that about 77 percent of the eligible children have actually been examined at the age of seven. Of the remaining children, half of them have been lost to the study, but efforts are being made to find them.

These data are now being continually analyzed and reported. Two volumes of the collected bibliography of reports from this study: Volume 1 from 1963 through June 1969 and Volume 2 from July 1968 through June 1969 have been published. These are available from the Perinatal Research Branch, NINDS, Wiscon Building, Room 708, Bethesda, Md. 20014.

Research into inborn metabolic errors is being supported in order to discover how early these diseases 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. The biochemistry of these diseases and the relationship of the biochemical activities to brain function are being studied. These studies, which are directly relevant to the development of mental retardation, are identifying the enzyme defects which are specific for the various diseases. Research is beginning to see if substitution therapy can be developed.

Studies are underway to attempt to link the pathological patterns of brain damage to functional development. In this area the Collaborative Study will be valuable in providing both normative data and incidence statistics relative to mental retardation.

The early diagnosis of mental retardation is frequently extremely difficult. 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 often follows hydrocephalus and brain tumors in childhood. Development of appropriate surgical or pharmacological therapy remains an objective of the Institute. The Institute is also supporting programs which investigate the mechanisms involved in meningitis or meningoencephalopathy to determine proper preventive and therapeutic approaches.

Mr. ROGERS. Now, where is this research mainly being done?

Mr. BLACK. Well, most of the research in retardation is being done outside of this particular program area.

Mr. ROGERS. Outside of NIH?

Mr. BLACK. No. Outside of the particular program area.

Mr. ROGERS. This program?

Mr. BLACK. Yes, sir.

Mr. ROGERS. How did you get it fed into your programs?

Dr. JASLOW. Through reports, conferences, and written articles.

Mr. ROGERS. Do you initiate any research yourself?

Dr. JASLOW. We had a very small research program.

Mr. ROGERS. \$126,000?

Dr. JASLOW. Which was geared primarily to applied areas. Most of it went, for example, for one project which was to try and develop a module, an architectural module that would be more conducive to working with young children in an educational setting, preschool setting.

Mr. ROGERS. That was your research?

Dr. JASLOW. Yes, primarily.

Mr. ROGERS. Do you have any more?

Dr. JASLOW. Yes, we had a small program, a small grant, about \$23,000, to try to develop a simplified means of early identification testing mechanisms for earlier identification of those children who might have delays in development.

Mr. ROGERS. Well, you are really not handling any research?

Mr. NEWMAN. For all intents and purposes, the Division of Mental Retardation is not handling any research, Mr. Congressman.

Mr. ROGERS. Who has the responsibility for research in this area? Who gives leadership to it?

Mr. BLACK. I think that comes from the Office of the Assistant Secretary for Health and Scientific Affairs, Dr. Egeberg and Dr. Steinfeld, because most of this research is being carried on in the Health Services and Mental Health Administration and NIH.

There is also research of a different kind carried on in the Office of Education. They have some research programs there.

Mr. ROGERS. What did they do?

Mr. BLACK. This is research in training and teaching, and I think these figures indicated that they are spending in the neighborhood of \$1 million a year.

Mr. ROGERS. About a million.

Mr. BLACK. Under cooperative research activities, vocational education activities, et cetera.

Mr. ROGERS. Well, I would very much like to know if you could supply for the record what Dr. Egeberg and the Surgeon General have designated for research targets, what they are trying to accomplish and how much money is being devoted and what success they are having.

(The following information was received for the record:)

MENTAL RETARDATION RESEARCH TARGETS

Nutrition and mental development probably ranks first among the Department of Health, Education, and Welfare's mental retardation research targets. Second would be the investigation of genetic defects including inborn errors of metabolism and mongolism. Closely behind would be the relationship of the events of pregnancy of the outcome of the child and studies of how retarded children learn (See insert on page 35).

The 1970 HEW budget request included almost \$30 million for research on mental retardation. The 1971 budget request increased this amount to nearly \$31 million.

Some of the outstanding accomplishments of this program include the rubella vaccine, the measles vaccine, and the national phenylketonuria (PKU) screening program.

Mr. ROGERS. Has there been any breakthrough in this within the last 2 or 3 years from research?

Dr. JASLOW. Well, the immunization program would be one, and another would be the recent determination of the fact that some

viruses, what they call slow-acting viruses, are causing brain damage that we once thought was due to developmental factors.

Mr. ROGERS. Is there anything that can be done about the viruses?

Dr. JASLOW. I think the next thing would be developing a vaccine.

Mr. ROGERS. Is that being done?

Dr. JASLOW. I do not think they are quite that far along yet, sir.

Mr. ROGERS. Would you let us know the details on that and the status of it?

(The following information was received for the record:)

RESEARCH ON VIRUS IN THE PREGNANT FEMALE

The attached press release provides further details on the research on slow acting viruses requested by Mr. Rogers (Testimony—Page 38 line 8).

It is clear from this report, that although major first steps have been taken, further research will be required prior to the development of preventive vaccines or intra-uterine-therapeutic measures.

[News release from United Cerebral Palsy Associations, Inc., New York, N.Y., Apr. 27, 1970]

SERIOUS DISORDERS, THOUGHT TO BE CONGENITAL, MAY BE LINKED TO VIRUS IN THE PREGNANT FEMALE

NEW YORK, N.Y. April 27.—“For years the medical community has assumed that several serious disorders of the nervous system, including cerebral palsy, are the result of congenital defects. Now, evidence shows that these disorders may be related to viral infections in the mother during key periods in her pregnancy.”

These findings, and others, were reported by Guy M. McKhann, M.D., professor of neurology at Johns Hopkins University Medical School, when he spoke at a symposium on premature birth held today in New York City. The symposium was sponsored by the United Cerebral Palsy Research and Educational Foundation. Dr. McKhann was reporting on experiments conducted by himself and two other doctors in the neurovirology group of the medical school's department of neurology. Richard T. Johnson, M.D., who holds an endowed Eisenhower professorship provided by the UCP Foundation, began his experiments at Case Western Reserve University. When he came to Johns Hopkins in 1969, he joined forces with Robert M. Herndon, M.D., who also had come to Johns Hopkins' newly formed neurology department, headed by Dr. McKhann.

In opening his presentation, Dr. McKhann described the work of Dr. Johnson and Dr. Herndon. He noted that “they undertook this experimental effort because the notion of congenital disorders in the developing nervous system just doesn't make any sense, particularly when the disorder of the fetus is not present in preceding generations.” With this in mind, Drs. Johnson and Herndon began looking for another cause. Going on their earlier observations of virus-infected mothers, they decided to test the effects of viruses on the fetuses of the cat and the hamster. As a result of this work—carried on before and after both doctors came to Johns Hopkins—they found that the fetus has what they call a “selective vulnerability.” This means that specific cellular groups in the nervous system can be damaged by the viruses at specific times during fetal development.

In the first experiment, Dr. Johnson examined the brains of newborn hamsters whose mothers had been given a viral infection at particular stages of pregnancy. The offspring were found to have hydrocephalus, a condition characterized by an abnormal increase in the amount of fluid in the cranium, enlargement of the head, wasting away of the brain, and loss of mental powers. However, an examination of the brain did not indicate that the virus was responsible for the disorder. So, the doctor next examined the brain of an infected fetus which had been removed from the uterus. In this way, he found the virus at work, selectively affecting cells in the lining of the channels through which the spinal fluid must pass. The cells affected by the virus were destroyed, blocking passage of the fluid. This blockage has previously been ascribed to a congenital defect.

In the second experiment, Dr. Herndon infected pregnant cats with a virus which attacks cell groups in the developing brain. These cats produced offspring which had detectable structural defects, such as shrunken cerebellums. How-

ever, in this experiment, too, an examination of the brain did not show that the virus had caused the defects. But later, when cat fetuses, like the hamster fetuses, were examined before birth, Dr. Herndon found that the virus was attacking certain groups of developing nerve cells in the brain. When attacked, the nerve cells were either destroyed or changed so extensively that they could not perform their original function in the brain.

Dr. McKhann also described anoxia (lack of oxygen), another fetal phenomenon that can lead to cerebral palsy in the newborn child. Cerebral palsy, a dysfunction of the motor nervous system, is associated with an excess of myelin, an insulating material that normally encloses nerve fibers. Recent observations using electron microscopy have shown that in cerebral palsy-afflicted infants, this excess myelin occurs around non-nerve cells which should never have been insulated at all.

Dr. McKhann and his colleagues have proposed the hypothesis that during the period of myelination—which occurs at a definite point in gestation—the human brain is so affected by anoxia that it is not controlling the myelination process. The next step planned by Dr. McKhann, is to attempt to reproduce anoxia in newborn monkeys, and other laboratory animals. Then they would determine whether excess myelination can be prevented after the monkey brain has been subjected to a shortage of oxygen, or whether the process of myelination is irreversible.

While this last project is yet to be completed, Dr. Johnson's and Dr. Herndon's viral experiments have provided their answers already. "From their findings," said Dr. McKhann, "it is clear that a group of serious human disorders which we in the medical community have previously thought to be the result of congenital defects, may be related to maternal viral infection."

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Mr. NEWMAN. May I add something here, Mr. Rogers?

Mr. ROGERS. Yes.

Mr. NEWMAN. I think, again, that many people do not consider research in this same area as basic preventive research, which is what you have been speaking to, but there is gaining movement in what you might call service-related research. That is, once a person does have an impairment, such questions may be asked as: "What are the best ways to maximize this person's development? for a retarded person to get work?" "What are the kinds of supportive services that might be necessary?"—We do have research; we do have social-service type research in demonstration projects supported by the Social and Rehabilitation Service.

Mr. ROGERS. Would you let use know the extent of those for the record; what they are, and the amounts of funds and personnel being devoted?

Mr. NEWMAN. Yes, sir.

(The following information was received for the record:)

SOCIAL AND REHABILITATION SERVICE: RESEARCH AND DEMONSTRATION ACTIVITIES FOR THE MENTALLY RETARDED

The Social and Rehabilitation Service operates a number of research and demonstration programs for the mentally retarded designed to enrich their lives through the provision of services and to enable them to become self-supporting through the rehabilitation process. In addition, research projects are supported overseas under the Public Law 480 program which complement and supplement the U.S. domestic program. Each of the research and demonstration programs for the mentally retarded currently operated by the Social and Rehabilitation Service are described below:

REHABILITATION RESEARCH AND DEMONSTRATIONS

The areas of research under this program include evaluation of aptitudes and abilities, analysis of jobs which the retarded can perform, opening of new occupational areas for the retarded, improvement of counseling techniques, development of new methods of training and job adjustment and evaluation of facilities and programs to assist the transition of the retardate from the institution or other sheltered environment to community participation. The 1965 Amendments to the Vocational Rehabilitation Act recognized in particular the needs of retardates by providing up to eighteen months of services during which the individual is evaluated for employment potential. The Amendments of 1968 have focused attention on the necessity for research on retardation as a function of cultural deprivation. Current programs of research and demonstration are, therefore, increasingly concerned with new approaches to retardation in ghetto areas, and especially model city neighborhoods.

Culture-fair assessment of rehabilitation clients has become of increasing importance as selection for jobs has extended to cultural handicaps. A simple pictorial inventory which will assist in solving this problem for retardates is the recently completed Vocational Interest and Sophistication Assessment Test standardized on 3,000 retarded persons and predicting what job an individual will find most satisfying to him in terms of his interests.

The Bourbon County Schools work-study project, one of several in Appalachia, was established in Kentucky, a State with one of the highest dropout rates in the nation. The retarded subjects were children of impoverished parents; the majority were from homes of tenant or farm laborers with earnings well below poverty level. Despite the massive handicaps of cultural deprivation and mental retardation among the youngsters studied, this project, over its three-year term, reported a dropout rate of only 5 percent. Moreover, 88 percent of the sample of youngsters served have been trained and placed in jobs thus contributing not only to their own independence, but also to the economic welfare of their parents and the community at large.

During the past three years, the State Divisions of Vocational Rehabilitation have conducted energetic programs to place the retarded in a wide variety of civil service jobs. The District of Columbia, DVR and George Washington University have completed a follow-up study of the first 2,000 mentally retarded workers placed with the Federal Government throughout the country to determine how effective the program has been and how to improve and expand it to State governments as well.

The most significant recent research and demonstration development for the retarded is a set of six projects to be carried out jointly by the National Urban League, Family Services Association of America and the National Association for Retarded Children. These are demonstrating in model city neighborhoods new and more effective ways to reach culturally deprived and disadvantaged families with essential services for members of the families who may be retarded.

In fiscal year 1970 for rehabilitation research and demonstration activities the amount of funds available is \$1,116,000. These funds will provide support for approximately 22 projects similar to those described above.

The President's Budget for 1971 includes a request for \$1,008,000 to provide support for approximately 19 projects for research and/or demonstrations for rehabilitation of the mentally retarded. Research will be done on controlled social environments that will elicit from the retarded greater capacities for growth and development and compensate for deprivation experienced in ghetto or rural poverty neighborhoods. Experimental programs will be devised to train retardates to better meet and overcome perplexing situations encountered in

work and social contacts. It has been found that a great proportion of the population that is functionally retarded is associated with the effect of severe cultural deprivation and poverty. These groups will likely be found concentrated in the ghettos of inner cities. Comprehensive community action demonstration programs will need to be provided to properly serve and train these groups for work and increased earnings. Besides the younger retarded, there are and will continue to be substantial numbers of older retarded in urban and rural areas living in pockets of poverty and marginally employed—will require special services to raise the level of their earnings and personal competence.

It is planned to call on experts in the field of mental retardation throughout the United States and in other countries with advanced programs for rehabilitation of retardates, and stimulate information exchange among professionals working in retardation and lead to new approaches and application of research. Demonstrations in the improvement of services to the mentally retarded to provide them with opportunities for making a useful contribution to our society and to increase their earning capacity will have special emphasis in 1971.

REHABILITATION RESEARCH AND TRAINING CENTERS

The three Mental Retardation Research and Training Centers currently sponsored by the Social and Rehabilitation Service of the Department of Health, Education, and Welfare, are the University of Wisconsin, the University of Texas, and the University of Oregon. The research conducted by these centers is broadly directed to a wide range of psychosocial, vocational, or other fields of rehabilitation, and also to specific problems in the many aspects of rehabilitation of the retarded.

In 1969, the three Mental Retardation Centers conducted 101 research projects. They are continuing to seek out the cause of retardation, to assess the potential for education and rehabilitation, to develop training and remedial programs suited to the needs of the retarded, and to ascertain the actual learning and socialization difficulties encountered by the retarded. Approximately the same number of projects will be supported by the three centers in 1970 and 1971.

As an example of the kind of research conducted at the Centers the University of Wisconsin Research and Training Center has initiated a study on the major personality factors which characterizes the adolescent retardate residing in the community. These adjustment characteristics have a significant effect on vocational success and hence, the data obtained from this study will make possible a determination of the effectiveness of behavior modification and other reinforcement techniques.

Other research projects will focus on such high priority areas as improved work adjustment methods for motivating and training the dependent or potentially dependent for employment, new physical restoration techniques for increasing the mobility potential of the severely handicapped, and factors effecting the etiology and acquisition of cultural deprivation and mental retardation in inner city populations.

For fiscal year 1970 a total of \$855,000 was available for operation of the three Rehabilitation Research and Training Centers for Mental Retardation. In fiscal year 1971 the level of support will be \$900,000.

INTERNATIONAL RESEARCH ACTIVITIES

Since the beginning of the research and demonstration program in 1961, 22 projects in various aspects of mental retardation have been approved. The range of research interest is very broad encompassing both medical and non-medical projects as well as clients of all ages. Types of projects that are now in progress include: investigations concerning the incidence of phenylketonuria; experimentation with new techniques for training the mentally retarded; and investigations on the medical, psychological, social and cultural aspects of mental retardation. During the past year, projects dealing with mental retardation were approved in Ceylon, India, Israel, Poland, and Tunisia.

The amount of funds (U.S. dollar equivalent) available in fiscal year 1970 for research projects overseas is \$80,000. In fiscal year 1971 it is estimated that \$450,000 will be available to support research projects overseas similar to those described above involving several countries currently operating under the international research program.

RESEARCH GRANT PROGRAM

The Research Grant Program of the Division of Mental Retardation, Rehabilitation Services Administration, has an appropriation of \$126,000 for fiscal year 1970. The program is designed to discover and develop new knowledge and techniques, and to gather information for the increased efficacy of services for the mentally retarded and, as a corollary function, to expedite the translation of this knowledge into new and improved programs. The research is generally of a highly practical or applied nature, being program oriented, and is complementary to overall program efforts of the Division; to plan, conduct, evaluate and coordinate a comprehensive nationwide program of care for the mentally retarded. Projects funded under this small research program have covered such investigative areas as 1) methods of increasing flexibility in the architectural design of residential facilities for the retarded, 2) the development and evaluation of a system of perceptual motor training to foster pre-vocational skill development in seriously retarded children, and 3) the relationship between mental retardation and delinquency. The last area, currently under investigation, has strong implication for more effective handling of the retarded offender, in both the social service and justice systems.

STAFFING

The mental retardation rehabilitation research and demonstration activities described above are conducted by the Division of Research and Demonstrations, the Division of Research and Training Centers, and the Division of International Activities of the Office of Research and Demonstrations. The total staff assigned to these three Divisions is 57.

Mr. ROGERS. Why is the administration's bill abandoning the State formula plan of financing construction and services and going to a Federal project type of program?

Mr. BLACK. There are two reasons, I think, for that, Mr. Rogers.

The first one is, as indicated in the testimony, that we think that the level of funds we have requested and the level at which the Congress, until now anyhow, has been willing to appropriate does not lend itself to a formula-grant program to the extent that the level of funds we envision in some of this legislation would.

The second one is that the problem of mental retardation is not spread evenly among the States or among the populace. Because of this very high incidence of retardation in poverty areas we think that with this level of funding and this peculiar problem of our target population we can get to the target much more effectively with a project grant program.

I might point out, as far as the States are concerned, that we would, as we indicated here, guarantee that each State would get no less than they did last year for construction funds. We also are giving these States an opportunity to review and comment on any project application.

Mr. ROGERS. But the basic decision would be made here, not in the State?

Mr. BLACK. The final decisions would be made as they are in other project programs, yes, sir. They are, in some cases, made in regional offices. As you know, one of the things we are trying to do is to decentralize our decisionmaking process.

Mr. ROGERS. Are you also decentralizing the mental retardation program on a regional basis?

Mr. BLACK. All of these various programs, as you know, are under review in the Department to see how we can simplify the whole grant mechanism and cut down the time between an application and the

final decision on the grant. The authority to approve grants under parts C and D of the MR Facilities Act has been delegated to the regional offices.

Mr. ROGERS. Now, I think you gave me the authorization figure that had been requested over the length of the program here. What was that figure, again?

Mr. BLACK. Well, the figure I used was for the last 3 fiscal years.

Mr. ROGERS. Yes.

Mr. BLACK. Which was \$191 million that had been authorized.

Mr. ROGERS. And how much—

Mr. BLACK. \$62.7 million, about a third of that, actually appropriated.

Mr. ROGERS. And how much was requested by the President's budget?

You did not give us that.

Mr. BLACK. I do not have that breakdown, Mr. Rogers, but it is very close, I think—it would be quite close, I think, to the figure that was appropriated.

The Congress has increased it a little bit—the request—but not substantially.

Mr. ROGERS. They increased it some over the budget request?

Mr. BLACK. Last year, for instance, the budget request was \$20 million, and the House approved \$24 million. This is for the part covered only by this act. The House approved a little less than we requested for staffing, and I think about \$4 million more was approved for construction.

Mr. ROGERS. Well, this is what concerns me, that unless there is an advocate, and a case is built, the Congress is pretty much going to go along on the recommendation—and this is the point I am trying to make. I do not know why the Department cannot get across to the budget the inflationary aspect of poor health, and if you come in with an adequate request to really run an effective program, I think the Congress will respond, because they have pretty much gone along with recommendations.

I think if you come up with adequate requests the Congress will respond, and I would hope that this administration would relook at this program rather than sitting back and simply letting the budget cut us all, letting the health care disintegrate and increase health costs.

So, I would hope the Department would do that. I personally feel that where we have programs that are planned, we know they are working and they are getting out to the people. These ought to be buoyed up. I do not object to change, but I do think we need to increase these programs rather than cut them down, and I would think, where we have on-going programs in States, where plans have been made, it is not very well to disrupt that and say, "Now, we will make all of the decisions for you up here." I do not think that is a very realistic approach, and I do not feel that the Congress is going to feel that that is a very appropriate way to approach this field.

Mr. BLACK. Well, I think we would agree with that.

The question is whether this program is really working as we would want it to.

As I said, when you look at these figures showing where the mental retardation is and where these programs are going, there is some question as to whether it is working as effectively as it might.

Mr. ROGERS. What is happening in the State of Massachusetts?

Mr. BLACK. Dr. Newman can answer that. He came here from Massachusetts.

Mr. ROGERS. Fine.

Mr. NEWMAN. I think, if I am up to date on the developments in Massachusetts—

Mr. ROGERS. You might want to expand on that and mention other States as well.

Mr. NEWMAN. I can tell you some of the things that are happening that perhaps might be instructive.

Firstly, Massachusetts was one of the States in which a decision was made to develop parallel lines within its agency which had given basically institution services to the retarded before that—parallel lines between mental health and mental retardation. What this meant, in effect, was that there was a recognition, which was increasingly becoming apparent over the country, that mental illness and mental retardation are two different entities, and that they affect people in different ways. Some people who are mentally retarded do have some overlays of disturbance. Although people who are disturbed are not necessarily retarded.

But this is, of course, a recognition that has been developing in this country over the last decade—and even longer.

So, that was the first thing I think that was significantly new, a new reorganization, so that as far as the mentally retarded in this State and in other States—because I do not think that Massachusetts is untypical as far as the mentally retarded are concerned—community services could be developed under this new authority and the focus shifted away from the institution. An attempt was made, and is now under way, to get to the people who are retarded, prevent them from getting into institutions in the first instance, and have them better able to cope within the community, within their families through the kinds of services that we are, in this program, supporting in the community.

The other thing that I think is of particular interest in Massachusetts is the fact that an office or a bureau of retardation was established at the Governor's level and there was recognition that retardation is an interdepartmental and public-private responsibility, and people who are retarded turn up everywhere, in all kinds of agencies, in all kinds of public, private departments and voluntary agencies.

So, there is an overview, then, at the Governor's level in Massachusetts, and an attempt is being made through this vehicle to see that these programs do affect retarded people in an integrated and coordinated way, which is going to maximize the categorical programs and available services.

These are some of the things that I can think of off of the top of my head.

Mr. ROGERS. Could the States assume any more responsibility do you think?

Mr. NEWMAN. I think some States can and are, and other States are not going to as quickly.

Mr. ROGERS. Now, will the proposed administration legislation actually be compatible with it?

Mr. NEWMAN. Well, I would say that there is room, in the current administration proposal, there is room to administratively encourage those States to focus on rationalizing their State programs and also encouraging other States to try to push ahead.

Mr. ROGERS. What about the Rehabilitation Services Administration, their program goals, are they compatible with that?

Mr. NEWMAN. I do not understand your question, sir.

Mr. ROGERS. Well, you have got general program goals for rehabilitation?

Mr. NEWMAN. Yes.

Mr. ROGERS. For the way this is administered?

Mr. NEWMAN. Yes, the general program goal being to try to expand our notion of serving all handicapped people and helping them to maximize their potential and to help as many as we can to gainful employment.

Mr. ROGERS. So, with this legislative approach, of being willing to extend in any way, if we can be helpful, if they have a disability, although it may not fall right in the mental retardation, we try to help. And can we incorporate that?

Mr. NEWMAN. I would say that, as Mr. Black has informed the committee, there really is probably, no essential incompatibility with the goals of the administration proposal and the committee proposal, given all of the funds that might be available for this program.

The question is: Given the possibility of a small amount of money being available in the immediate future, how should we organize ourselves to make these limited funds go the furthest?

Mr. ROGERS. Yes.

Well, in conclusion, I will say this, that I think our effort is very small in this whole area, that we could prevent great expenditures of money by stressing prevention more. We could bring in expanded programs here; we could bring them into society where we would not have to then spend many tax dollars simply in a maintenance program. I do not think that we are really on top of this program yet, and I would hope that the Department would be the advocate and the salesman for health on these programs to the Budget Bureau, and, surely, those of us in the Congress will try to stand behind you and be helpful in every way.

But I think that I have not seen enough fight yet in upping these figures, because we know they are needed and we know they will save money in the long run if properly spent. So, instead, we fall into the Bureau of the Budget, and I know this is difficult to do, but I think we are going to have to make a more sustained fight, and I think the Members of Congress will help and support you in those efforts.

Mr. BLACK. Mr. Rogers, I want to assure you that the Department is an advocate and it is a salesman. As we have said to this committee on other occasions, sometimes we have gone to the Budget Bureau and pushed hard for things and we did not get them, but at least we are making our case, and we are going to continue to do that. Obviously, the Budget Bureau has to make some decision in a larger context, even, than ours. But I do want to emphasize this, that on this particular program, in this whole area of mental retardation, we do have some serious questions about overlap and duplication, and the questioning this morning has indicated the way this particular program is just spread all over the Department.

Now, we have a coordinating committee, which is the Secretary's Committee on Mental Retardation, and then, as you know, the President's Committee on Mental Retardation. But the Secretary's Committee is made up of agency heads from different parts of the Department who have something to do with mental retardation, and it is more of a committee for exchanging information than a tightly knit operating arm of the Department. There is a history of this development of which I am sure you are aware, and I will not repeat it here.

I can say to you in all sincerity that before we come in and ask for a major increase—which is what some of the figures in this other legislation call for, a major increase—in any one part of this \$600 million program we really do want to take a good look at it and make sure that we are making maximum use of all of these dollars that we are spending.

Mr. ROGERS. I think it is good to take a look, and I think you do need to bring together within the Department these functions. Now, what concerns me is that you come in and you ask these programs be changed the way you are doing when you have not yet presented your program of what you want us to go on. I would rather go ahead and continue with the way we are doing it, because the States are operating, it is being effective, your particular phase of this \$600 million, I think, and we know what the need is—we know we need to meet these problems—and I would rather continue our program and try to begin to meet the need until the time you are ready to come in and give us your new approach.

In other words, Mr. Black, that does not stop you from coming in at anytime, because this committee will be willing to help you, I am sure.

Mr. BLACK. I do not think that our change is quite that dramatic, because, first of all, the staffing grants in the present program are not a formula-grant program; they are a project-grant program anyhow. So, really, what you are talking about here is changing the construction part of it to that kind of a program, and, that being the case, then, we come to our second point of need.

And, here again, when you look at these figures—starting with this one that I cited of 75 percent of the mentally retarded being in poverty areas—they show that of the 310 projects which had been funded only 64, or 20 percent, have been in poverty areas. So, we think there is a need to take a new look at that part of it with these dollars we have available for particular programs and try to target those on the areas where the need seems to be the greatest.

Certainly, by the time we have another extension of this program due we will have completed all of the reviews and I hope will have been able to rationalize and make more effective the many activities the Department has underway.

Mr. ROGERS. Thank you.

Mr. BLACK. It is also true that we certainly share your interest on research and prevention, and I want to make sure that we get into the record something from the program people in those areas. I think you will find, when you have had more time to study this report of the Secretary's committee, that a lot of these questions are pretty well answered in there. But we want to make definitely sure that the report reflects exactly what we are doing in these other areas.

Mr. ROGERS. Yes, I would hope so, because I am not impressed with the research effort that I have learned about so far, and, secondly, I would hope that you, in your position, would try to encourage the Secretary to think of reorganizing the Department to the extent that he would start putting into the command channel of the health personnel all of these programs of medicare and medicaid. It ought to be done and administered and get this increase of \$2 billion. It is not having impact in this health like it could if it were administered by health people. I hope you will be considering that. I think it is essential. Thank you.

Thank you, Mr. Chairman.

Mr. JARMAN. Dr. Carter?

Mr. CARTER. No questions.

Mr. JARMAN. Thank you, Mr. Secretary, and your associates, for being with us this morning.

Mr. BLACK. Thank you, Mr. Chairman.

Mr. JARMAN. Our next witness is Dr. Elizabeth Boggs, chairman of the Government Affairs Committee, National Association of Retarded Children, accompanied by Mr. Karl Schmeidler, president of the Virginia Association for Retarded Children.

I might say at the beginning of the testimony that the time factor is always with us, and the House goes in at 12 each day, and if it is possible to submit the full statement for the record—which the committee can study—and then make comments or highlights on that statement, it would be helpful to the committee.

STATEMENT OF MRS. ELIZABETH M. BOGGS, PH. D., CHAIRMAN, GOVERNMENT AFFAIRS COMMITTEE, NATIONAL ASSOCIATION FOR RETARDED CHILDREN; ACCOMPANIED BY KARL SCHMEIDLER, PRESIDENT, VIRGINIA ASSOCIATION FOR RETARDED CHILDREN, AND VICE CHAIRMAN, GOVERNMENT AFFAIRS COMMITTEE, NATIONAL ASSOCIATION FOR RETARDED CHILDREN

Mrs. BOGGS. We would be very happy to do that.

I would also like to say that Mr. Schmeidler is the vice chairman of the committee on governmental affairs, as well as being president of the Virginia association, and I have asked him to come along particularly because he could speak so clearly from the point of view of a particular State, which is neither the best nor the worst, as he himself will say, and we would like to request permission to let him submit subsequently for the record a statement specific to Virginia which will simply be an example of how things have changed in the past 10 years.

Mr. JARMAN. The committee will be glad to receive your full statement, Mr. Schmeidler.

Mrs. BOGGS. We think it is because of these changes since 1963 that there is a need for a change in the structure of legislation. That is why we want to thank all of the members of the committee here present who do sponsor H.R. 14237 which does contemplate changes in the structure, in response to the experience we have had.

I think you know about us, in the National Association for Retarded Children. We are the spokesmen, I think, for the consumers of services; we are representatives of the retarded and their parents, their families. However, ours is an open membership organization, and many of the

providers, the professional people, belong to our organization; in addition, we have been very proud to have members who are simply public-spirited citizens who recognize that mental retardation is a great problem.

We have about 200,000 members in all of the States of the Union, and, indeed, on some military bases overseas, I might add.

Our approach to you is not one based on mere theory and statistics; we are pragmatists; we are on the firing line, and I think that will be true of some of the other public witnesses, too.

We can speak not only of the satisfactions and successes that we have been experiencing in the past few years, particularly with this legislation, but also of the very serious frustrations we have encountered, and some of those frustrations we would like to ameliorate by seeing a modification in the form of the legislation as you propose.

Mr. JARMAN. The committee is very conscious of your active work in this field, and we are pleased to have you back with the committee this morning.

Mrs. BOGGS. Thank you very much, Mr. Chairman. We are pleased to be with you, because we know of your long-standing interests—all of the members of the committee—and your efforts on behalf of this legislation at the time it came up for revision last time.

I would like to say a word or two about prevention. I was really delighted to hear Mr. Rogers bear down on that subject. It is one of particular interest to me, because I happen to have the privilege of sitting at the present time on the National Advisory Child Health and Human Development Council (NICHD), in NIH, which has the major designated responsibility for research related to mental retardation. It has a mental retardation program. Research is not the responsibility of the witnesses who appeared here, and I can appreciate their not being on top of that part of the black book.

As it happens, I did prepare originally as a part of my prepared statement a section on prevention, and I removed it because I felt that it was not appropriate, but, in view of your interest, I would be glad to reinsert it.

Mr. ROGERS (presiding). I would like to see it.

(The section on prevention was replaced in the prepared statement before printing of the hearing. See p. 224, this hearing.)

Mrs. BOGGS. We feel strongly about the need for prevention, and we recognize that prevention has to take place in many places and cannot focus really in one agency.

I will perhaps have a chance to come back to that, although I do not want to take your time away from the bill before us. The bill really deals with services and the means to secure services through the development of personnel and facility resources.

I think this committee hears a good deal about comprehensive programs. Most of the things that come before you that are called comprehensive are comprehensive but only within the confines of a particular disciplinary approach. You hear about comprehensive health or comprehensive mental health or comprehensive vocation-rehabilitation services. We, however, are concerned about comprehensive services from the point of view of an individual who is a human being with quite a wide range of problems, and we recognize that comprehensive services for the mentally retarded cannot be the sole function of a

particular agency nor can they belong exclusively to one agency. We recognize that health, education, welfare, rehabilitation, housing, employment—all of these must have an input. We here defend the fact that the Department has sought—and has succeeded to some extent—to make all of its agencies aware that the mentally retarded are part of the caseload in education—the total target group of children who need education—and the groups of people who need vocational rehabilitation, health services, welfare services, and so forth.

All of us, as normal people, need comprehensive service, and we cannot go just to one place to get it.

I would like now to speak particularly to the legislation and the two bills which are somewhat similar. One, the Senate-passed bill, S. 2846, and your own bill that you sponsored, H.R. 14327. The Senate bill was significantly amended in the Senate. It reduced the timespan to some extent, and the authorization, so it is now nearer to your own in those respects. The project-grant authority, which it now incorporates, is based on the provisions of the administration proposals contained in H.R. 15160, while retaining a consolidated State-formula-grant authority, which I think is of the utmost importance if we are to build on what has been going on in the past.

So, S. 2846 provides, for the first time in the field of mental retardation and other developmental disabilities, the basis for a State-Federal partnership comparable to those already developed in such fields as health, mental health, and vocational rehabilitation.

Inasmuch as disabled persons may also benefit from certain other federally assisted programs in health, education, and welfare, the Senate bill specifically specifies that the benefits of the proposed legislation should fill in the gaps and fill in the areas that are not now covered by existing legislation. Thus, it helps to make comprehensive something which now exists in pieces. We do believe that S. 2846 does constitute a move in the direction of consolidation.

We would like to say that when Mr. Black says—and I am quoting him:

We believe that it is desirable to amend the Mental Retardation Facilities Construction Act in ways which would simplify it through consolidation and make it more flexible and encourage use of available resources in the most effective manner.

We would entirely agree with him.

At the same time, we feel quite strongly that legislation along the lines that you have supported will do this more effectively than the administration's proposal. We do see, after a year of discussion and debate, that there may be a couple of further relatively easy amendments that could well be made to the proposed legislation. We would hope that they may be made and that the bill would be reported and passed expeditiously in view of the imminent expiration of the existing statutory authority which closes out in a couple of weeks. This is through no fault of your own, since your bill was introduced last October.

We want to point out that 10 years ago only a few States had engaged in any kind of a systematic interdepartmental planning and coordination of their programs for the retarded which, also, to the extent that they had them, could be found in a number of departmental settings, education, health, welfare, mental health, and so forth.

Thanks to the foresight of Congress, a small amount of Federal funding was made available, following the 1963 session, through the means of Public Law 88-156. This money became available primarily in the period 1965 to 1968 for intensive and comprehensive State planning in mental retardation. Every State responded to the opportunity, and these funds helped to give focus to a larger effort which was based on aroused citizen interest on behalf of the retarded.

I might mention that a study was made of the process of planning that went on and some of the byproducts of this planning. This study was conducted under the auspices of Dr. Conrad Seipp who, at that time, was in the School of Public Health at the University of Pittsburgh. Dr. Seipp subsequently mentioned to me that he thought that it was rare indeed that the Federal Government got so much mileage out of so little money as they did in connection with this mental retardation planning. I have mentioned this hearing to Dr. Seipp, and I think he will be preparing a short statement, based on his findings, which he will submit to you and which, if you are so disposed, you might include in the record.

We are asking that this State planning effort which was induced and stimulated by the Federal Government be recognized as something to be built upon and not thrown aside and discarded, as we feel would happen if we go back to a simple project-grant authority which, in fact, we have had since 1963. If we are to move forward as a nation with some community of purpose in this field, with some common commitment to develop a program for the mentally disabled behind our very valid State pluralism, we must have a more significant money stream which blends with and colors the efforts and plans of the States and communities. It must build on that which has gone before, give some consistency to the promise of Federal partnership, and relate to trends already apparent in parallel fields such as rehabilitation, social services, education and health services.

In our opinion, the time has passed when demonstration grants and project grants, each of which must be individually approved by the Federal agency, can be a primary vehicle by which the Federal Government can influence State and local policy toward national program goals in mental retardation.

In the fields of health, education, welfare, and rehabilitation, the proportion of Federal funding is a major one, and provides major inducements to the State and local governments to allocate their own funds. These Federal funds can and do provide a significant impact on both the quality and direction of State and local funding in this field. A similar effort must be made on behalf of the mentally retarded and otherwise developmentally disabled in respect to those particular types of needed services which do not fall appropriately under other generic or categorical programs. We need to fill in the spaces between. We have called this an interstitial program—what is proposed in the legislation.

I think we have to address ourselves to the question of funding levels. If we read Mr. Black and Dr. Newman correctly, they really say that they could contemplate the kind of legislation you have proposed, or the legislation that the Senate has passed, but they just cannot do it now, because of the money bind that they feel they are in. We want to say first of all most emphatically that authorization levels

should reflect the need. The levels should state the amount of money which could be spent effectively as we address ourselves to this program in successive years. The levels of Senate 2846 are minimal in this respect. As a matter of fact, in testimony given before the Senate it was shown we could use \$100 million in construction alone in the field of mental retardation, not counting any of the services or any of the other forms of disability. There is no reason why the program in mental retardation, for developmental disciplines, should enjoy a better approximation between authorization and inadequate administration proposals in spending than the Congress has provided in other segments of health and education legislation.

The idea that we are going to have unrealistic expectations because there is a gap between the authorization and what the administration proposes to spend is somewhat dubious in view of the fact that everybody has come to expect that the administration is not going to come up to the authorization any more. Let us at least proclaim fairly that there are gaps, that there are needs that are not being met. The discrepancy between \$100 million authorization and \$20 million BOB request is not unusual these days.

In testimony before the Senate committee and again this morning, the administration witnesses inserted a record of what the administration has ferreted out, thanks to the diligence of the Secretary's Committee on Mental Retardation, about what benefits are flowing to the retarded in various noncategorical programs of the Department. As we pointed out earlier, the mentally retarded are citizens, too, and it is only just that they receive their share of attention from the agency which dispenses health, education and welfare services generally. Thanks to the work of the Secretary's committee, this administration and previous administrations, has a clearer picture of this composite effort on behalf of the retarded than it has of what HEW is doing across-the-board for any other comparable heterogeneous group of people, whether it be the aged, disadvantaged, unemployed, physically disabled, or mentally ill, or drug abusers. HEW is doing a great deal for the mentally ill, for example, that is not being done by NIMH, but they talk as though it were the only agency.

Here this morning, you made it very clear, yourselves, in your questioning that there are activities outside of the scope of responsibility of the Division of Mental Retardation which are much more extensive than those that are in the Division. The Division's ability to operate, and its responsibilities, are, in fact, quite limited, but it is to those responsibilities that the legislation is addressed. The programs administered by the Division, and which include those authorized under the expiring legislation, are a small, but critical part of the total of \$606 million claimed as being expended by the Department for the retarded in 1971. That total appears to be increasing, but the DMR portion—Division of the Mental Retardation—is decreasing both proportionately, and absolutely. Despite the talk about more effective use of funds, the increasing total, is realized, will have less effect in shaping national goals in mental retardation in 1971 than did the lesser total in 1968. We think this particularly will be so if the administration bill prevails.

We hear a great deal about restraining inflation, and I commend Mr. Rogers for pointing out the fallacy of some of the approaches we

are taking in the name of economy, the short-sightedness of it. Without analyzing where money is coming from for many new or enlarged programs for the arts, sewage disposal, and other worthy goals, and we ask only that the money being claimed as spent for mental retardation be spent to maximum advantage for the benefit of the retarded and multiply handicapped.

The administration has projected from \$370 million for services and grants, for mental retardation exclusive of income maintenance, for 1971, of which \$105 million is estimated to be claimed under title XIX, medicaid for skilled nursing home care of the retarded in institutions for long-term care. Almost a third of what has been identified by the administration as "service" money is Federal money that is going into that "medicaid" channel. No mention is made of the intent of the administration, and no mention is made by the administration witnesses of the intent of the administration as embodied in H.R. 17550, of the social security amendments—which have already passed the House—to reduce Federal participation in such care by 33½ percent. We respectfully submit, therefore, that a true representation of expected expenditures would show a savings of one-third of this medicaid item for retarded or the equivalent of \$35 million for 1971. If the savings were to be retained for the retarded, combined with the funds presently requested for the division of mental retardation, and a consolidated program developed along the lines delineated in the Senate bill, or your bill, it would be no problem to reprogram enough money to meet the authorization specified in your bill. If implemented with rigor and conviction, as we are sure such a mandate could be if implemented under Commissioner Newman's direction, the results would be very dramatic. If this is not done, we will continue to hear claims of great Federal expenditures for mental retardation, but we will not see proportionate results.

Now, I have included in our statement some material on university affiliated facilities, which we regard as a very important resource. I think you heard the administration say this morning that although the Division has the responsibility for administering those portions of the expiring legislation which deal with this subject, they are in fact, not requesting a single dime, nor did they request any for 1970. The only identified expenditures, Federal expenditures, going in this direction, come from the maternal and child health services through section 511 of the Social Securities Act, and these are quite restricted in terms of uses they can be put to. However, you have other very competent witnesses coming before you on this subject, and in the interest of what I am just hearing [bells] I will certainly skip over that.

Toward the end of our statement, we have listed a couple of suggested amendments which we respectfully submit. I want to particularly mention that if you should use the Senate bill as a basis of your action, we would hope very much that you would include in it the particular provisions that you have put forward for encouraging the association of junior colleges with the university affiliated facilities program.

We also agree with the administration that the cost of acquisition of land, which is now excluded in construction projects, should be included. These costs can be quite high in urban areas where we have such difficulty in getting these centers established. It may very well

be that, if you count the total costs of the project, the part applicable to cost of land is a major portion, and very much reduces the actual Federal participation in the total cost.

Finally, we call attention to the fact that the matching for construction, as proposed in either your bill or the Senate bill, is controlled by section 401 of the present act, which is common both to mental health and mental retardation. We have agreed that this should be common. We do not want to put one program at a competitive advantage with the other. This section was amended when you passed the Community Mental Health Centers bill, but I think the way it came out was a little surprising to everybody, or at least to some of us; we would respectfully suggest that there be removed all reference to the so-called Federal percentage—which is a carryover from the old Hill-Burton Act and is not completely applicable even in Hill-Burton any more. For programs which are in areas that are not designated to have the special preferential matching for urban and rural poverty—where 90 percent would be the top limit—we would hope matching would be as determined by the State but under the limit of 66 $\frac{2}{3}$ percent.

Now I should point out to you that the pressure on the States is such that there will be a tendency to spread this money around, and to reduce the Federal matching within the State in accordance with the State's own sense of priorities. This will not in any way increase the amount of money that the States have, but it will give them a greater say-so about how they will use it. It will permit them to recognize special needs in areas that do not happen to meet the urban or rural poverty tests. Those are the two suggestions that we have.

Basically, we believe the Senate bill included some other improvements, which we hope you will accept, and we know that you will have to come to an accommodation on the authorization. We hope you will. I think you have agreed with us that the kinds of authorizations that are being proposed by the administration as being equated to the present level funding, are quite inadequate. We hope we may see eye-to-eye on that.

We do want to thank you very much for your sponsorship of this legislation and your interest in holding hearings and what we hope is an assurance of early action.

(Mrs. Boggs' prepared statement follows:)

STATEMENT OF ELIZABETH BOGGS, PH. D., CHAIRMAN, GOVERNMENTAL AFFAIRS COMMITTEE, THE NATIONAL ASSOCIATION FOR RETARDED CHILDREN

We of the National Association for Retarded Children deem it a privilege to be able to commend and thank publicly the Chairman and members of both parties of the Subcommittee on Public Health and Welfare, and other members of the House, who have joined to sponsor H.R. 14237 and similar bills, the purpose of which is to provide successor legislation to the Mental Retardation Facilities Construction Act of 1963 as amended (Part I of PL 88-164). We find desirable features also in the Senate passed bill S. 2846 and the Administration bill H.R. 15160.

Although H.R. 14237 and S. 2846 were very comparable when first introduced, the latter bill was significant amended in the Senate. The project grant authority which it now incorporates is based on the provisions of the Administration proposals contained in H.R. 15160, while retaining a consolidated state formula grant authority. Thus S. 2846 would provide, for the first time in the field of mental retardation and other developmental disabilities, the basis for a State-Federal partnership comparable to those already developed in such fields as health, mental health, and vocational rehabilitation. Inasmuch as disabled

persons may also benefit from certain other federally assisted programs in health, education and welfare, S. 2846 would direct the benefits of the proposed legislation to areas of need not now covered by existing programs.

Part C of the 1963 Act, which now authorizes formula grants to States for the construction of community facilities for the mentally retarded would be replaced by a combined formula grant and project grant program covering construction, services and service-related training. In addition, the scope of Part C would be broadened to include not only the mentally retarded, but also persons suffering from certain other closely related developmental disabilities, such as cerebral palsy, epilepsy, and related neurological handicaps. Of the funds appropriated for Part C, not more than 20 percent could be reserved for project grants to be administered by the Secretary of Health, Education, and Welfare, and the remainder would be allotted by formula among the States for planning, administration, services, training of personnel, and construction, in accordance with an approved State plan.

The existing authority under Part D of the 1963 Act, which now provides support for professional and technical personnel in facilities for the retarded, would not be extended. Part D would not be repealed, however, since it authorizes the continuation beyond June 30, 1970, of grants initiated prior to that date. Some \$10.99 million has been requested for such grants for 1971. In the future, the purposes of Part D would be carried out under the broadened authority of the new Part C.

We urge that S. 2846 with certain further amendments be reported and passed expeditiously in view of the imminent expiration of the existing statutory authority now provided by PL 88-164.

The mentally retarded, the developmentally disabled, are people—children and adults—who have long-term handicaps, often multiple handicaps, stemming from a great variety of causes, most of which are operative in the earliest years of life. Their tragedy is their own and their families'. It is also society's. The federal government is now paying out well over ½ billion dollars on income maintenance and long-term care of this group of people, and the states are spending billions of their own.

PREVENTION : ITS POSSIBILITIES AND LIMITATIONS

Research, and action based on research, is enabling us and will enable us in the future, to reduce the toll of these disabling conditions but this will be a long slow process.

In the Federal Government major responsibility for support of basic and mission-oriented research in the biomedical and social sciences related to these goals has been vested in the National Institutes of Health. Part A of the Mental Retardation Facilities Construction Act of 1963 (administered by National Institutes of Health and Human Development) has made possible the creation of 12 major research centers in mental retardation and related aspects of human development which will contribute in a unique way to our knowledge of the multiple causes of developmental disorders in children and young adults. The authority for construction provided in Part A was allowed to expire in 1967 but authority for major federal operational support of relevant research in these and other appropriate settings is found in Title IV of the Public Health Service Act and is expected to continue.

The National Institute of Child Health and Human Development and the National Institute of Neurological Diseases and Stroke are expected to spend more than \$40 million during 1971 for research and research training which have a direct bearing on the prevention and alleviation of mental retardation and other neurological disorders originating in childhood.

Our Association strongly supports the intensification of research whose goal is prevention, but we recognize that such research will be of little benefit to those who are already disabled. Moreover, it cannot be expected to have sudden and dramatic impact on the total problem of long-term disability. Rubella immunization, for example, can prevent a few thousand cases of mental retardation resulting from a German measles epidemic. This is dramatic indeed for the individuals saved, but it pares the problem down by only a fraction of a percent. Moreover it does nothing for the victims of the epidemic of the mid-sixties, nor for the children and adults whose disabilities arise from other causes. Their need is for the best possible services to alleviate their conditions, to maximize their potentials within the limits imposed by the underlying disability, and to permit them to live in dignity as members of a society which cares; it is the

disabled now in our midst who are the focus of the legislation which you are considering today.

We come before you seeking authorization for funds which can be used to create more effective programs of management and habilitation, and better development and use of resources on their behalf. It is not only the number of federal dollars but also maximizing the leverage which they exert at the state and community level with which all of us are concerned.

MEETING THE NEEDS OF THE DEVELOPMENTALLY DISABLED

These mentally retarded and otherwise handicapped children and adults are people, citizens, human beings, with the full gamut of human needs to which society attempts to minister through its myriad agencies of government and the activities of its voluntary sector. Society works for all of us through its schools, its health centers, its rehabilitation facilities, its clinics, its social agencies, its employment offices, its housing projects. The developmentally disabled are found in the target populations of all these organized activities, many of which are infused with federal funds. Many developmentally disabled children and adults receive service in these settings, and properly so. Half a million are in school; perhaps 100,000 receive vocational rehabilitation services of some kind; a quarter of a million receive "adult disabled child" benefits under the Social Security system.

These are all valuable and appropriate components of the needed "spectrum of services," but the spectrum is neither continuous nor complete. Some essential links in service are missing. Most needed professional skills are in short supply. We must also make delivery and distribution of services more equitable. There is a need for interstitial funding which will fill in gaps, provide a kind of glue to make the pieces stick together, and focus attention on special needs which fall between the responsibilities of existing programs, traditional disciplines and non-functional categories of clients. There is a need to do these things in a way that strengthens and upholds State constitutional and statutory responsibilities in meeting human needs while fostering the planned dispersion of services so as to make them both accessible and acceptable at the community level. All this requires both long- and short-term planning and coordination. Such planning must be sustained. The commitment must be a continuing one. The administrative back-up must be provided by which the human potential and physical resources are mobilized in a systematic way.

Ten years ago only a few states had engaged in any systematic interdepartmental planning and coordination of programs for the retarded. Thanks to the foresight of Congress, a small amount of federal funding was made available under PL 88-156 over a three-year period (1965-8) for intensive and comprehensive state planning in mental retardation. Every state responded to this opportunity. These funds helped to give focus to a larger effort based on aroused citizen interest on behalf of the mentally retarded.

The effort thus begun will continue in some form in most States even if the federal government reneges on its implied commitments under the only piece of legislation (PL 88-164), in the history of the Nation which was designed to provide specialized facilities for research, training, and community service for the mentally retarded. However, such repudiation will result in loss of momentum, increasing gaps in federal credibility. The Administration bill (H.R. 15160) and the Administration testimony would, in our opinion, constitute such an abandonment of commitment. It proposes, in effect, a return to the status quo ante 1963. By substituting a federally administered project grant authority with very limited funding in place of the basic State-federal partnership which could logically emerge from H.R. 14237 and S. 2846, it offers little more than we might have had from the federal government if there had been no President's Committee on Mental Retardation under President Nixon and no President's Panel under President Kennedy.

Such a project grant authority can be effective as a supplement to a basic program of formula grant support to States, as provided in S. 2846; if left to stand alone, however, and limited to the level of \$20 million which the Administration has cited as its intended token input under H.R. 15160, it will have about as much effect on the course of history as a few summer showers have on the course of the Mississippi River. The time has passed when demonstration grants and project grants, each of which must be individually approved by a federal agency can be the primary vehicle through which the federal govern-

ment could influence State and local policy toward national program goals in mental retardation.

For these reasons also we prefer the language of Section 137 as it appears in the Senate bill and in Mr. Waldie's bill (H.R. 15968) rather than in the corresponding section of H.R. 14237.

If we are to move forward as a nation with some community of purpose and with some common commitment to the developmentally disabled behind our very valid State pluralism, we must have a more significant federal money stream which blends with and colors the efforts and plans of the States and communities. It must build on that which has gone before, give some consistency to the promise of federal partnership, and relate to trends already apparent in parallel fields such as rehabilitation, social services, education and health services.

In these latter fields the proportion of federal funding is a major one and provides major inducements to the State and local governments to allocate their own funds. These federal funds can and do produce a significant impact on both the quantity and direction of State and local funding in these fields. A similar effort must be made on behalf of the mentally retarded and otherwise developmentally disabled, in respect to those types of needed service which do not fall appropriately under other generic or categorical programs.

FUNDING LEVELS AND PRIORITIES IN MENTAL RETARDATION

We wish to state most emphatically that authorization levels should reflect need, the amount of money which could be spent effectively in succeeding years of the program. The levels in the Senate bill S. 2846 are minimal in this respect. There is no reason why this program should enjoy a better approximation between authorizations and inadequate Administration proposals in spending than the Congress has provided in other segments of health and education legislation. Let us proclaim fairly the gaps. A discrepancy between a \$100 million authorization and a \$20 million BoB request is not unusual these days.

In testimony before the Senate Committee, on S. 2846, Administration witnesses inserted a record of what the Administration has ferreted out (by the diligence of the Secretary's Committee on Mental Retardation) about what benefits are flowing to the retarded in various non-categorical programs of the Department. As we pointed out earlier, the mentally retarded are citizens too, and it is only just that they receive their share of attention from agencies dispensing health, education and welfare programs generally. Thanks to the work of the Secretary's Committee, this Administration and previous Administrations have had a clearer picture of this composite effort on behalf of the retarded than it has of what HEW is doing, in toto, for any other comparable heterogeneous group of people, whether it be the aged, disadvantaged, unemployed, physically disabled mentally ill, or drug abusers. We are amazed that after ten years of internal and external reviews of programs and needs in mental retardation the Administration is still stalling for more time to study and review while a valuable program founders.

The program administered by the Division of Mental Retardation, which include those authorized under the expiring legislation are a small but critical part of the total of \$606 million claimed for 1971. The total is increasing; the DMR portion is decreasing, both proportionately and absolutely. Despite the talk about more effective use of funds, the increasing totals, if realized, will have less effect in shaping national goals in mental retardation in 1971 than did the lesser totals in 1968. Particularly will this be so if the Administration retreat represented by H.R. 15160 is allowed to take place.

We hear a great deal about containing inflation. Without analyzing where money is coming from for many new or enlarged programs for the arts, sewage disposal and other worthy goals, we ask only that money being claimed as spent for mental retardation be spent to maximum advantage for the benefit of the retarded and multiple handicapped. The Administration has projected some \$370 million for "services and grants" (other than income maintenance) for 1971, of which \$105 million is estimated to be claimed under Title XIX (Medicaid) for skilled nursing home care of the retarded in institutions for long-term care. No mention is made of the intent of the Administration (as embodied in H.R. 17550 which has already passed the House) to reduce federal participation in such care by 33¼ percent. We respectfully submit therefore that a true representation of expected expenditures would show a saving of

1/3 in this item or the equivalent of \$35 million for 1971. If these savings were to be retained for the retarded, combined with funds as presently requested for services and facilities for the mentally retarded, and a consolidated program developed along the lines delineated in S. 2846, it would be no problem to reprogram enough money to meet the authorizations specified in Title I of H.R. 14237. If implemented with vigor and conviction, as we are sure such a mandate could be implemented under Commissioner Newman's direction, the results could be dramatic.

If this is not done we will continue to hear claims of great expenditures but we will not see proportionate results.

TITLE II—TRAINING PERSONNEL TO HELP THE DEVELOPMENTALLY DISABLED

Your Committee has a traditional interest and leadership role in training in the allied health professions. The implementation of service systems for the retarded and those with related disabilities requires additional modes of training with special emphasis on interrelationships between persons in health and in other helping professions, especially education in its broadest sense. It is these interdisciplinary approaches to training that are fostered by the programs of the so-called university-attached facilities for the mentally retarded.

The fundamental purpose underlying the university-affiliated concept is to provide models of service, in which the best possible programs utilizing the full range of needed professional skills can be demonstrated as part of the interdisciplinary training of those personnel whose careers will bring them into responsible contact with the mentally retarded and their families.

Too often in the past training of personnel in these professions has tended to be isolated from the real world of retardation. Many medical students, for example, have little if any contact with the retarded until they were confronted with a complex and unfamiliar problem in their offices. Many sociologists, psychologists, nurses, lawyers, clergymen, occupational and physical therapists and even teachers are exposed to retardation in merely textbook fashion, and yet their skills and understanding are crucial to the proper handling of the problems of the mentally retarded and their families.

It has often been the case that people seeking help for their retarded child must proceed through a battery of seemingly duplicatory procedures—none of which appears to be coordinated in the best interests of the retarded individual. By training those people whose skills are required for the habilitation of the retarded in a joint venture, greater understanding among the professions involved can be created. It is the intent of these programs that this kind of team effort will materially improve both the quality and quantity of services available.

As a result of the concept of training exemplified by university-affiliated facilities, students in the various disciplines which should be brought to bear in dealing with the retarded receive training in an integrated method and are better able to "do their thing" cooperatively rather than competitively.

Interdisciplinary teamwork is not a new problem-solving technique. Perhaps the most dramatic utilization of this mode is our Nation's highly successful space program wherein great variety of scientific skills are orchestrated in a "mission-oriented" approach.

We may view the problems of the retarded in a similar fashion with the "mission" being the provision of the best, most efficacious and most cost-effective system of human services adapted to the needs of the retarded.

Title II of both H.R. 14237 as sponsored by the members of this Subcommittee and other members of the House, and S. 2846 as passed by the Senate, provides for a continuation and expansion of Part B of PL 88-164 as amended. Part B established the program for the construction of university-affiliated facilities for the retarded.

Since the initiation of this program in 1963 18 facilities have been funded in universities throughout the country. Ten are "on the drawing board" awaiting availability of funds and an additional, perhaps 30 universities, would be interested in and are prepared to initiate such a program pending its extension and funding. Part B in the original Act provided for construction funds alone. Program support has been forthcoming from a variety of federal and state agencies.

Title II of your bill, (H.R. 14237) and of the bill as passed by the Senate, (S. 2846) continues the construction provision and adds a program of grants for certain types of administrative costs, or, if you will, basic operational

support. The funds under this provision will permit the university-affiliated centers to fund on a continuing basis the essential core personnel without which other federal, State, and private aid cannot be efficiently mobilized and deployed. We feel that this provision for administrative costs will result in greater efficiency and applicability to the retarded population.

To a much greater extent than the research center, regionalization of the UAFs is required. For this reason, we strongly urge the establishment of additional centers. The staff organization of such centers can well proceed prior to actual construction, as has already been demonstrated, and we stress that funds to be made available under Section 122 should not be limited to centers which have already received construction grants.

H.R. 14237 has an additional, extremely promising provision which would encourage potential university-affiliated centers to cooperate with junior colleges in the training of personnel. NARC supports this provision.

This Committee has taken leadership in the comprehensive planning approach to the delivery of health services. Among the priorities established by you has been the creation of regional centers and regional plans. We would like to point out at this time, that the university-affiliated facility concept fits in very neatly with an overall planning and delivery approach. These centers can act as training and research resources on a regional basis and have the potential for the innovation and creativity for which you have expressed such outstanding support.

The UAF program as originally created by Congress has been seriously jeopardized by budgeting high-handedness and a lack of understanding in high places in the past four fiscal years. In fiscal years '68-'71, funding was provided only in 1969 and only in the amount of \$9.1 million. In neither FY 1970 or '71 were any funds requested for construction under Part B. This has left us with 18 programs approved and funded for construction, where at least 40 are needed if regional needs are to be served. I am sure I need not explain to this Committee the deleterious and demoralizing effect that this administrative hostility is having on the progress of the UAF program. The existing university-affiliated centers do not rely exclusively or in many cases even primarily on federal funding for their operation. In the past two years, for example, they have made great strides in acquiring funding from multiple federal, State and private sources. Nevertheless, if the program is to be continued and be successful it is vital that Congress make quite clear to all concerned that the program is developing consistent with the goals heretofore set forth by you.

This Committee has long recognized that it is appropriate that federal funds should flow directly to universities where there is a nationally recognized need for the program as set forth in Title II. Under other circumstances we might have supported the idea of "consolidating" funding of those university programs with other project funding for training, demonstration and construction. As things stand NARC therefore urges this Committee to retain intact the language in Title II of H.R. 14237. It is most important that this program remain as a separate title.

SUGGESTED AMENDMENTS TO S. 2846

We respectfully submit the following suggestions for amendments to S. 2846:

1. First, we heartily endorse the provision of H.R. 14237 (Section 203) which gives priority to applications from university-affiliated centers which have arranged for the participation of a junior college in their programs of training personnel for service to the retarded. The pertinent sentence should be incorporated in S. 2846.

2. We endorse that provision of H.R. 15160 (Section 3(c)) which includes the cost of acquisition land in the cost of construction. We see the absence of such a provision as a real and practical obstacle to the development of facilities in inner city areas. We urge the inclusion of this provision in the final bill.

3. We believe that the amendments made this year by PL 91-211 to Section 401 of the present Act (which section applies to both the mental retardation and mental health centers construction projects) have inadvertently produced an inequity which should be corrected at this time. We respectfully urge the removal of all reference of the "federal percentage" in section 401(h)(2). The inclusion of this term means that in a few States the federal share will be limited to as little as 36 or 38 percent across the State (except in areas of urban or rural poverty where 90 percent would be the top limit). In the spirit of fostering State responsibility for setting priorities we believe that the "amount determined . . . in the State plan" . . . but not to exceed 66 2/3 percent represents a sufficient restriction and would permit better management of priorities at the State level. It should be

pointed out that where there are limited funds available the general tendency in the States will be to hold the federal share down in order to spread these funds among as many communities as possible. However, the option to provide more favorable matching, where needed, should not be denied to the State.

The National Association for Mental Health joins us in this request.

4. We urge that the same preferences be given to disaster areas as to areas of urban and rural poverty. This suggestion comes to us as a result of the experiences on the Mississippi coast following Camille, in which other forms of disaster aid could not be secured for the rebuilding of facilities for the retarded which were destroyed. Specifically this would mean amending Section 401(h)(3) of the Act as it stands, and also Section 134(b)(10) as proposed in H.R. 14237.

SUMMATION

We believe that the Developmental Disabilities Services and Facilities Construction Act of 1970 as it passed the Senate provides the needed basis for implementing that part of the federal role in services to this group of people on which the federal government appears to be in greatest danger of defaulting. We come to the Congress (as we have in the past when an Administration has faltered) hoping that you will recognize an imminent injustice and will respond (as you have in the past) to a critical need by affirming a strong federal responsibility.

We look forward to early passage of this legislation and extend our thanks to all the sponsors of H.R. 14237. Our special thanks to you, Mr. Rogers, for your leadership and encouragement.

Mr. ROGERS. Thank you very much, Dr. Boggs, for an excellent statement and, as you know, all of the members of this subcommittee have joined together in introducing the bill which I think gives some indication of the fact that the committee knows of the urgency of the program. We hope to be able to act quickly on this legislation.

Mrs. Boggs. I am glad to see minority sponsors here as well as yourself.

Mr. ROGERS. Any questions?

Mr. KYROS. I only have one question, Mr. Chairman. Thank you. Dr. Boggs, what are we going to do to increase the availability of services for mentally retarded children in rural areas such as in a rural State like Maine, or other areas of New England?

Mrs. Boggs. I am very glad you asked me that question. I was not expecting it but I am very glad to have an opportunity to speak to that, because in this legislation, and particularly the Senate bill, great emphasis is placed on services—not necessarily services which are “in facilities.” If we are to have a broad definition of services—and it was broadened slightly in the Senate—I think it desirable to include, for example, transportation. Now, as any rural school system knows, you do not get the children to the school unless you provide transportation, and when one only pays salaries of professional or technical personnel, you do not always get the transportation, which may have to be contracted for rather than provided with one's own personnel.

The other point I would like to make in relation to the rural areas, relates to a very interesting project that was tried in Maine several years ago. I thought it was particularly creative, and I would like to see it reactivated. I was speaking to Dr. Anderson about this the other day. In this project, women who lived in rural areas, and who had some educational background that related to mental retardation—whether it was in social work or education, or some such, some familiarity with the problem—who were housewives and not available for full-time employment, but had qualifications, were enlisted on a salary basis, with expenses paid to go in their own cars to visit the families in the rural areas, where it was believed there were retarded

children, to see them in their own homes, come to understand what they perceived to be their problems, what they thought was most urgent, to assist them to make use of such resources as there were and to bridge the gap between the planning of new resources and the needs seen by the consumers themselves. I thought it was a very creative thing, and it is the kind of thing that could be funded under the legislation which we are proposing. If that kind of service is to be really useful, you want to initiate it, and you want to be able to sustain it. The very fact that in this instance it was organized with a project grant, and then dropped, is an example of the kind of thing that worries me about just going with the project grant approach.

Mr. KYROS. Thank you very much, Dr. Boggs.

Mr. ROGERS. Mr. Nelsen?

Mr. NELSEN. I have no questions. Thank you.

Mr. ROGERS. Dr. Carter?

Mr. CARTER. I certainly have enjoyed the presentation. I think it has been very good, and I agree with Mr. Rogers, and I support the principles that Dr. Boggs has so well enunciated today.

Mr. ROGERS. Thank you.

Mrs. BOGGS. Kentucky is one of the States that has been moving along very impressively in the last few years.

Mr. CARTER. They have done quite a nice job.

Mr. ROGERS. Mr. Schmeidler, would you care to say anything to the committee at this time? I know you are going to prepare a statement for the record.

Mr. SCHMEIDLER. Yes, Mr. Chairman. I would appreciate the opportunity to say a few words at this point, and then supplementing by a more detailed statement subsequently.

Mr. ROGERS. Certainly.

STATEMENT OF KARL SCHMEIDLER

Mr. SCHMEIDLER. I am president of the Virginia Association for Retarded Children. I would say that the State of Virginia is not very different from most States; in some areas we have progressed a little further ahead, and in many other areas we have a long way to go.

In 1968, the State conducted a survey and determined that there were 141,000 retarded persons in the State. They were broken down into various categories and this gives us some clue of the extent of the problem, and the kind of facilities and programs that we needed. Actually, there has been, as in most States, much improvement in the past 10 years, and particularly in the last 2 years. I credit much of this change, much of the improvement to the impetus resulting from Federal legislation, and in particular, I am thinking about Public Law 88-156, which provided for comprehensive State planning. As Dr. Boggs said, with so little money as it had, it had a tremendous impact; it has resulted, really for the first time, in development of comprehensive plans for the mentally retarded, and changed the view from primarily orienting most of the programs and services in the State institutions, to both residential and nonresidential facilities, with a concept of trying to keep the mentally retarded out of the institution and in the community, and to utilize their talents, to develop them, to train them, so that they can become more worthwhile and productive

citizens. The results and findings within a very brief few years, is that this has been occurring.

Now, in addition to Public Law 88-156, we have had many advantages resulting from other Federal legislation such as Public Law 88-164 dealing with the facilities construction and staffing. As I said, only a few years ago, the primary focus of our action in Virginia was centered around the State institutions, and very little attention was paid to any other program than services. This attention really was only relative and this is true in so many States. Our facilities were badly overcrowded, old, the waiting lists were at least 5 years, and there were no training facilities, and once a person entered an institution, they rarely ever emerged.

Although we still are very much concerned with institutions and the recognition that a certain number of retarded will be still institutionalized, and the State has put a good deal of money into institutions, we still face the same problems of inadequacies in most of them. Recently, there has been a trend, in Virginia, as in other places, toward regional centers.

At this point I would like to make two comments. In going into the regional center concept, and attempting to put regional centers, within the communities, and to make them small, and to enhance the training facilities, we found first that we ran into a great deal of difficulty in land acquisition. The cost of land, say, for a training center in northern Virginia, Fairfax County, was very high. The State did not have the money for this, and the local communities were required to pay for the land, and in some of the communities it was exceedingly expensive, when we are talking in terms of many thousands of dollars per acre.

We have a second regional facility planned for Norfolk, the Norfolk area, and for 2 years now they have not yet been able to obtain all of the funds and reach an agreement on the land, where that facility will be placed.

Secondly, as we go into regional centers and more training facilities we find another great lack is a lack of trained persons. Now, this is unfortunate in the areas where the first centers are going to be which are relatively privileged. It is even more devastating when we talk in terms of national priorities to place centers and focus our attention in the urban and rural poverty areas.

Our third institution, regional center, is scheduled for southwestern Virginia, which is one of these areas. What we have found from even the most cursory examination is the fact that there is an absolute dearth not only of professionally trained persons but subprofessionally trained persons, and it is exceedingly difficult to try to recruit people to go, not only to regional centers, but to any other facilities and services that we want to place in that part of the State. This is a very serious situation that we are facing.

Now, with respect to a few of the other changes that have taken place, for example, back in 1960 in Virginia we had a total of 252 classes for the retarded, of which 203 were for the educable or mildly retarded, and 49 classes for the trainable or moderate. In all, less than one-quarter of the counties and cities had any class whatsoever for retarded persons, and throughout the State only 4,203 children were enrolled in these classes, and the total State assistance was \$771,000.

In 1969 the situation improved. There are now 13,500 retarded children attending over 800 classes in the State, and the State has paid out over \$6 million for direct assistance for teachers of special education, and over \$1 million for related specialists and for transportation.

During the next 2 years the State intends to support an additional 400 special education teachers. Notwithstanding this growth, we have found from the State survey that there are over 50,000 retarded children in the State who are eligible and who have the capacity for being educated. So, we still have less than one-quarter of the mentally retarded at the educable or trainable level attending these classes at all. For example, in the city of Danville in southern Virginia, with over 50,000 persons, we have only one class at the present time for the trainable retarded. So, here again, we have quite a long way to go.

Mr. ROGERS. Would this be typical of most States?

Mr. SCHMEIDLER. I would say typical of many States. Many States are in similar conditions to ours. As you know, we have a few areas that are built up where your living, your incomes, are higher, such as northern Virginia, the Tidewater area, Richmond, and in addition we also have large areas, rural population areas, where the income is very low, and I would say there are many States similar to ours, I would guess, yes.

Mr. ROGERS. Thank you.

Mr. SCHMEIDLER. The State, as you know, is making an effort, and has for many years. The fact that so many of the Senate legislators in our general assembly and the chairmen of committees come from rural areas, has focused a good deal of attention on these places. But, what we have to realize is that we need far more programs, far more structured programs, far more extensive programs, and they cost far more money.

With respect to a comment Dr. Boggs made earlier about transportation, that is the key, not only in special education classes, but to every service, bringing the children to the clinic, bringing the children to the workshops, to the day care centers and the activity centers. Any community program rises or falls on the extent to which transportation is available, and this is a key factor, and an expensive factor for most counties, and most counties cannot at all afford to undertake this themselves.

(The following statement was received for the record:)

STATEMENT OF KARL SCHMEIDLER, VICE-CHAIRMAN, GOVERNMENT AFFAIRS COMMITTEE; PRESIDENT, VIRGINIA ASSOCIATION FOR RETARDED CHILDREN, ON BEHALF OF THE NATIONAL ASSOCIATION FOR RETARDED CHILDREN

My name is Karl Schmeidler, and I am President of the Virginia Association for Retarded Children. We are one of state member units of the National Association for Retarded Children, and we have local member units located throughout Virginia. The situation in Virginia concerning the retarded, and the problems which we face are, I am sure, typical of those in many other states.

I would like to thank the subcommittee for the opportunity of appearing before you today. I would like to discuss briefly some impact which recent federal legislation has had upon the programs and services to the retarded of Virginia and why continued and expanded federal assistance is so important to us.

In 1968 the State of Virginia conducted a survey and determined that there were 140,780 retarded persons in the State.

A. IMPACT OF FEDERAL LEGISLATION

There have been many improvements in the care and training of the retarded during the past decade. I credit much of this change to the impetus provided by recent federal legislation which has broadened our outlook as to what can be done for the retarded and which has assisted us to finance many new programs and services.

1. One of the early important federal statutes was P.L. 88-156 providing for comprehensive state planning in mental retardation. Pursuant to this statute we and many other states made our first systematic examination of existing programs and services in the State. We adopted a comprehensive State plan to coordinate health, rehabilitation, employment and other programs for the retarded and to establish priorities among the various programs. In short this legislation led to a more balanced effort which did not focus entirely on institutional care but was also intended to keep as many retarded as possible out of institutions and to provide programs and services in the community to train and protect them. Thus, not only the State but also the local communities began to assume more responsibility for their retarded citizens.

2. Other federal legislation which followed, such as P.L. 88-164, which provided matching grants, led to far greater appropriations by the State and local communities to carry out the programs and services which they had assumed.

3. Another consequence of this federal legislation was the establishment of a position of Coordinator of Mental Retardation in the Division of State Planning and Community Resources in the Governor's Office, with responsibility for planning and coordinating programs affecting the retarded.

B. RECENT CHANGES

A few consequences in Virginia resulting from the adoption of a comprehensive State plan have been as follows:

1. *Institutions.*—Ten years ago the primary focus for State action for the retarded centered on our two State institutions. Very little attention was paid to other programs and services. Such attention on our institutions was, however, only one of degree. The institutions were old, outmoded and badly overcrowded. There were very few training facilities. The waiting list for admission averaged five years; and once a person entered an institution he rarely emerged.

Although improvements have been made at our existing institutions, they are still severely overcrowded. Many of the facilities are still old and inadequate, and there are still insufficient training facilities. All the institutions are severely understaffed and the employees are underpaid. For example, there are approximately 3,600 retarded at the Lynchburg Training School and Hospital, which is approximately 1,000 over its rated capacity. There are 1,400 mentally retarded at the Central State Hospital, Petersburg, which is primarily a hospital for the mentally ill. Until recently there has been only one teacher for the 360 children of school age at Central State Hospital, and other qualified staff is not available.

2. *Regional Centers.*—In 1966 planning was authorized for construction of a 500-bed regional center in Northern Virginia. This was to be a prototype for nine additional small regional centers to be located throughout the State where the retarded could be close to their families, receive proper care and training, and participate in the communities. Since then funds have been appropriated for construction of the first two centers—in Fairfax County in Northern Virginia and in the Norfolk area. Unfortunately the extremely high cost of acquiring land has delayed further plans in Norfolk. Also, inflation has caused delays of at least two years at the Northern Virginia center. Plans have had to be revised several times to reduce the size of the center and to eliminate training facilities, notwithstanding that the State has given the center a large supplemental appropriation.

3. *Education.*—In 1960 there were 252 classes for the retarded in Virginia, 203 of which were for the educable retarded and 49 for the trainable. In all, only one-fourth of the cities and counties of the State had any classes for the retarded, and only 4,203 out of an estimated 50,000 eligible retarded children of school age were enrolled in all the educable and trainable classes. The total State assistance to the counties and cities for special education in 1960 was only \$771,000.

In 1969 13,500 retarded children attended over 1,000 classes for the educable and trainable children, and the State paid \$6,150,000 to the counties and cities

to fund special education teachers' salaries and over \$1,000,000 for related specialists and for transportation. During the next two years the State expects to fund an additional 400 special education teaching positions.

Notwithstanding this increase in commitment to special education, there is still much to be done. Only one-quarter of the eligible children are receiving any education in the public school system, and most of the special education classes are limited to educable children. There are no classes for the trainable in large portions of the State; and practically no facilities for the multiple handicapped or for those with special learning conditions.

4. *Consulting and Diagnostic Clinics.*—In 1960 there were three Consulting and Diagnostic Clinics for early detection of the retarded, whereas in 1969 there were nine clinics. In addition there are two special diagnostic and rehabilitative clinics; one at the University of Virginia Medical School at Charlottesville, and the other in a comprehensive center in Norfolk.

Additional clinics are badly needed. There are long waiting lists for appointments at most clinics, and large areas of the State are located far from existing clinics. There is also a need for increased services at most clinics which will include counseling to the retarded and his family.

5. *Vocational Training.*—During the last five years there has been an increase in opportunities for vocational training extended to retarded youths. Although the majority of existing programs are for the mildly or educable retarded, there has been a limited extension to include the moderate or trainable retarded. During the past five years the State Department of Vocational Rehabilitation has paid out \$1,000,000 of federal funds and \$300,000 of State funds to rehabilitate 1,814 mentally retarded and other handicapped persons in 19 workshops. At present the Department is funding 22 workshops throughout the State.

In sum, only ten years ago there were very few community programs for the retarded. Most of the then existing services were operated by local associations for retarded children. Since their resources were limited, only a small number of retarded could be helped. Today, on the other hand, the State and local communities are operating more education and rehabilitation programs, and they have added new programs, including ones for pre-school retarded children, to provide recreation, activity centers, etc.

C. REGIONAL AND COMMUNITY PLANNING AND OPERATING OF PROGRAMS

1. *Regional Planning Districts.*—In 1968 legislation was enacted in Virginia to form 22 regional planning districts throughout the State with responsibility for over-all planning in economic, social, health, welfare, transportation, ports, water supply, and other matters. Planning for mental retardation is intended to be included in the regional plans.

2. *Community Mental Health and Mental Retardation Services Boards.*—Other legislation was enacted in 1968 for community programs and services for the retarded. It was recognized that the needs of the mentally retarded are so great that they cannot be met solely from any one source, and that cooperative efforts by the local community, State and Federal Government are required. It was also recognized that a large majority of the retarded can be cared for and trained in the local community; that it is cheaper to do so, and that this may enable many of the retarded to live more normal and useful lives.

This legislation placed an emphasis on local initiative to ascertain the needs of the retarded in the community. The local community boards were made responsible for developing, under State guidance, comprehensive plans for the retarded in their area. This legislation envisaged an increasing cooperation among the various State departments to lessen gaps or overlapping. The community boards were authorized to plan and administer programs of the various state departments. Finally, the legislation called for a sharing of funding by the State, local communities and, where applicable, other groups.

At the present time there are 18 existing community boards. In 1970 the legislature appropriated \$3,300,000 as initial funding for 1970-1971, of which \$1,800,000 was for operations and \$1,500,000 for capital expenditures. If requests from the local boards are considered to be a measure of the needs of the communities, it may be noted that most of the operating funds, as well as \$490,000 of the capital funds, are for mental retardation programs.

The legislature in 1970 also appropriated funds to the Department of Mental Hygiene and Hospital to acquire and train persons to provide assistance to the community programs.

D. UNMET NEEDS

1. *Rural and Poverty Areas.*—Notwithstanding the many improvements which have occurred in recent years there are still many unmet needs of the retarded in Virginia. For example, there are no facilities and programs for the retarded in large areas of the State, and particularly in the poorer areas. These latter have been found to have a higher rate of incidence of mental retardation, and in some instances more than double the national average. The State has recognized that these areas require much more assistance, for the local communities are too poor to provide any of the needed services. Although State planning has given priority to these areas, State funds are limited and are not sufficient to meet the needs.

2. *Lack of Trained Personnel.*—One of the principal unmet needs are for trained personnel in practically all fields pertaining to mental retardation, including special education teachers, speech and physical therapists, counselors, psychologists, etc. More and enlarged departments in the universities and colleges are badly needed to train professional persons. There is also a need to ascertain what jobs can be performed by subprofessional persons under the supervision of professionals, and training programs for paraprofessional persons should be instituted in our community colleges.

3. *Vocational Programs.*—There are many remaining gaps in our programs. For example, we are keeping more mentally retarded children out of institutions. However there are too few vocational education and training facilities and employment opportunities, as well as available workshops for the more than 57,000 mildly and moderately retarded adults currently in Virginia.

4. *Adult Centers.*—There is a vital need for adult centers located in the community to which adult retarded who previously have lived at home can go when their parents become old or die.

5. *Other Gaps.*—Other present unmet needs include short term and respite care centers, counseling and guidance services for the retarded and his family, protective services, and early infant and preschool care. Federal money will be required to help start many of these pilot projects to prove their worth. Without federal appropriations to supplement moneys which the State and community funds, it is doubtful that these projects can be started or, once started, will continue operations.

6. *Pending Grant Applications.*—At the present time there are at least six multipurpose centers in various stages of preparation in the State. An application for federal funds has been approved by the State for such a center in Portsmouth. The plans for a similar center in Alexandria are expected to be completed and approved shortly, and there are plans for centers in Prince William County, Norfolk, Roanoke and Bristol. Likewise the University of Virginia has applied for a federal grant for a university affiliated center in Charlottesville. If federal funds are cut off, it is very unlikely that any of these centers can be built solely with state and local money.

Between 1966 and 1969 seven community facilities have been approved for federal assistance under P.L. 88-164, at an estimated cost of \$2,495,806, of which the federal share was \$1,412,669. We believe that if continued federal assistance is not forthcoming that there will be little likelihood of obtaining sufficient State and local funds to assume the full cost of additional facilities.

E. FORMULA AND PROJECT GRANTS

The question whether federal funds should be made available to states in formula or individual project grants is important to us. We believe that we in Virginia, as well as our counterpart in many states, have become much more qualified and knowledgeable during the past years to ascertain our needs. Although we recognize the legitimate interest of the Federal Government to assign priorities in the payment of its funds, such as the priority to programs and services for urban and poverty areas, we urge that apart from these states should have freedom to ascertain their needs under general federal supervision rather than under a project grant system. We are concerned lest too close federal supervision inhibit responsible state action and throw us back into the situation of the past years. We prefer an approach where the Federal Government would establish criteria which would allow the states the right to modify their programs within the broad guidelines established by the Federal Government.

We also fear that there will be greater delay in obtaining approval for project grants. If so, the present rate of inflation may make it exceedingly difficult to carry out approved plans if much time elapses between submission of plans and their approval.

Federal guidelines for planning and construction grants have stimulated greater flexibility by state governments and a greater voice by communities and consumer groups. We would hate to see our newly organized and hard won community programs affected by delays, less flexibility and more rigid controls which may result from a project grant method of federal grants. We believe that such method will inhibit local initiative to develop community programs and will render the community boards and the State less able to take advantage of changing local conditions.

Mr. ROGERS. Thank you very much, Mr. Schmeidler. That is very helpful to get the ideas of the problems in a particular State.

Mr. KYROS?

Mr. KYROS. No questions.

Mr. ROGERS. Mr. Nelsen?

Mr. NELSEN. Recalling the legislation at earlier stages, under title III emphasis was on training personnel and, obviously, it has not really produced the personnel you need. Is that about the way it turns out?

Mrs. BOGGS. Well, the title III legislation has since been translated to the Education and Labor Committee. This was really pioneering legislation as it began in 1958, and was later incorporated in this bill in 1963 for reasons of convenience. I would say it has been extremely successful but it is limited to educational personnel, and we do have a considerable increase in the number of teachers, and in other people necessary in the educational system. I think the population has also been growing, however. I believe I am correct in saying that the Office of Education is now projecting that for the next few years we will have almost an equilibrium and balance between the needs for regular teachers and the regular children. But that in the area of special education we are still on the short side. We would be a great deal worse off if we had not had that legislation. The need for other than educational personnel has only been more recently recognized, and it is to the whole spectrum of personnel needs that the university affiliated facilities legislation—which is part of title I of the existing legislation—was addressed.

Mr. NELSEN. Now, I presume that if some of the smaller communities were to set up a facility for training it would be a bit of a burden, because the number of people is very limited. It would not justify the hiring of a teaching staff because work load would be out of proportion to the capability of the teachers. Is there any combination of areas, where two or three towns could get together?

Mrs. BOGGS. Of course, the way this is done is characteristic of individual States, which, after all, have the primary responsibility for running their public education, and also what we sometimes refer to as the day care activity, day training centers such as you have in Minnesota. The way these are organized will depend to a considerable extent in the State perception and planning and it should be that way. There are a number that have set the precedent of authorizing regional arrangements in which several communities do combine together.

Mr. SCHMEIDLER. I would like, if I may, to add a brief word to that. We had gone in 1968 and authorized regional planning, covering in many areas, including mental retardation. One of the important consequences is that we have gone into a development of community programs and community boards which give the initiative for many of the programs in the mental retardation area. This is not limited just to the one department, which is responsible for mental retardation,

but all departments focused in a board setup operating at a community level with general State guidance. We are bridging our programs of education, rehabilitation, training, workshops, and all of the other programs. Many of these boards are regional in nature. They cover a number of counties, and a number of cities, so that we can get the population basis that is sufficiently large to make it economically more feasible. We are just starting this, and the first funds were authorized by the Legislature this year and will be available July 1.

With respect to the question of the difference between formula and project grants, we have fought hard to involve the communities and the States into developing programs and developing initiative for new programs, especially with this new community program, where the States and the local communities are going to share the cost of centers, as well as to attempt to seek other means of Federal funding which is needed so badly for many of our programs. I would hate to see this initiative and development stifled by limiting Federal aid to project grant assistance, because I think it would hurt us very badly, and throw us back 10 years.

Mr. NELSEN. Transportation, as you mentioned, is a very major problem. There is a project that I worked on in my home county. It involved an abandoned country school with four rooms and a playground. Instead of buying an expensive facility, the facility was purchased for \$1. It developed that potential students were located in various school districts and although they have been able to work out an arrangement, transportation remains a major problem. We were surprised at the number that finally showed up to go for training. They have done an excellent job.

Thank you.

Mrs. BOGGS. Transportation is important if you want to reach the low-income families. This is true even in the big cities, because the middle-income families who are motivated can find transportation as a rule, but the low-income families are really left out on the limb.

Mr. ROGERS. Dr. Carter?

Mr. CARTER. Thank you, Mr. Chairman. Are you training paramedical personnel or the skilled personnel at your community colleges now in Virginia to assist you?

Mr. SCHMEIDLER. Really not yet. We have got plans to do this, and as far as I know, in some areas, yes, some of the physical therapists, we are starting to get some people trained, but whatever the number is, it is so few that it has not had much of an impact.

Mr. CARTER. What about your vocational schools, have you ever used them for training personnel? Do you have programs like that?

Mr. SCHMEIDLER. These are the programs that are just currently getting started, and I would say, before we know how much they can do, a little time has to pass. There was a recognition some time ago that, besides money, that personnel is a limiting factor on expansion of programs, and a recognition that we just cannot for the foreseeable future get enough professional trained people, and as a result we have gone over to the sub-professional.

Mr. CARTER. It is very difficult, and we do have the tools to work with, and some of them are being used in some areas, and I am thankful that they are.

Mr. SCHMEIDLER. We have a problem here, too, of needing additional funding and money is exceedingly tight. To get the university de-

partments and the people to be trained who will teach in them, this is a critical lack, we have far too few department where we can train people to go to the community college and the vocational schools to provide additional training. This is a key, and a first step, and, frankly, with all of the present needs, this is one of the areas in which we say we need additional help.

Mr. CARTER. Yes, sir, and of course that is true, and of course we should involve universities and go from them, many times, to your community colleges, who are under a central system, and I think many of our universities are interested in providing service. This goes also to our vocational school system, and in many cases they are responsive to the need of the group, and I see this in my area, some of them are training paramedical personnel, and I am extremely thankful because the need is really great for this.

How many regional centers do you have in your State?

Mr. SCHMEIDLER. None.

Mr. CARTER. I thought—

Mr. SCHMEIDLER. We have none in operation. We have the plans for 10 regional centers to be constructed, one to be opened every 2 years. The first center was authorized in 1966 for northern Virginia. It was funded for construction in 1968. A decision was made not to apply for the project grant to the Federal Government because of the long delays that were experienced by other States, and the feeling that it would take too long to get approval and get started. Inflation has had its impact, plus the cost of land, and as a result of this we have had to go back for rebidding twice, so the construction has not started yet for building, just for the land. A second center is in southeastern Virginia, which was not only authorized, but funds for construction were approved early this year. We are still having problems of land acquisition, and the high cost of land which the communities have to pay. The third center is in southwestern Virginia in the rural area, and we just have a very small amount for planning money involved, so when I said that we had them, they are not yet opened.

Mr. CARTER. Will these regional centers be satellites of areas, will they be the centers from which you will use your knowledge and training?

Mr. SCHMEIDLER. There are plans to combine and work with other regional facilities and local communities. There is a hope, of course, for the regional centers that we can train a large portion of the retarded to go back out to the community. In fact, a number of facilities that are planned are on an outpatient basis. In the northern Virginia and Tidewater area we are fortunate that the communities are wealthy enough, and the parents and other persons pay enough money that we have developed a good community program. They are better, frankly, than in any other part of the State.

Mr. CARTER. Do you have a State plan that would include every community from the regions and so on?

Mr. SCHMEIDLER. There is a 20-year State plan that would encompass the entire State. I would add this, and this is why I hesitated a moment ago when you asked the question. One of the first areas that got cut back as a result of the inflation, has been some of the training facilities for the Northern Virginia Center. What eventually will come forth, I do not know yet. It is going to require a hard fight to get this kind of center, community-oriented center that we want.

Mr. CARTER. Well, it is my feeling that you must have a real good plan and stick to it, and have it pretty well thought out and I think to that course.

Mr. SCHMEIDLER. Thank you.

Mr. ROGERS. Thank you, Dr. Boggs, it was most helpful to have your presentation before the committee.

We will now hear from Dr. William Gibson, president, Association of Directors and Administrators of the University Affiliated Centers and Director of the Mental Retardation Training Program at Ohio State University in Columbus.

STATEMENT OF DR. WILLIAM M. GIBSON, PRESIDENT, ASSOCIATION OF DIRECTORS AND ADMINISTRATORS OF UNIVERSITY AFFILIATED CENTERS; ACCOMPANIED BY DR. HARRIE R. CHAMBERLIN, DIRECTOR, UNIVERSITY DEVELOPMENTAL EVALUATION CLINIC, UNIVERSITY OF NORTH CAROLINA, CHAPEL HILL, N.C.

Dr. GIBSON. Thank you, sir.

Mr. Chairman, members of the subcommittee, it is indeed a pleasure to have this opportunity to appear before you. I represent the Association of Directors and Administrators of University Affiliated Centers throughout the Nation. Accompanying me today is Dr. Harrie R. Chamberlin, director of the University Developmental Evaluation Clinic, University of North Carolina at Chapel Hill. We represent the Association of Directors and Administrators of 19 approved and funded universities, 10 universities in the final stages of planning and program development, and approximately 30 other universities with a continuing interest in this program, who are in varying stages of planning.

It is an honor to appear today to indicate our strong support of the legislation, H.R. 14237, sponsored by you, Mr. Rogers, and by many of your colleagues. We are in agreement with the comments of Dr. Boggs, that with the appropriate amendments, H.R. 14237 presents an effective solution to some of the problems that we face in dealing with mental retardation.

We are sure it is apparent to you from the testimony this morning that the role and direction and the buildup and propensities for production of university affiliated centers is not as yet clearly apparent.

I would like to spend a moment then, to point out that UAC's are the outgrowth of State planning. We represent something which is unique and sometimes is threatening to certain professional individuals. We are interdisciplinary in the sense that we expect disciplines to communicate with one another. We represent a precedent for universities in the fact that this is the first major indication of their involvement in the community in terms of training and educational goals.

Again, the area of prevention is paramount is the development of these programs. Identification of a person in the family is the problem of the whole family, the stresses of pregnancy, the counsel that can be given requires input sometimes of many different kinds of disciplines, and then how do we translate these trained people to the community in a role that permits effective work with the problem as described. These programs have very dramatic capacity for training in-

dividuals: roughly 150 trainees—people spending up to a year in the program from each one of the participating centers—300 people who will have a major course of study in the area of mental retardation and may choose this as a career, and roughly 1,250 people who will be involved in each one of the facilities during the course of the year for short courses of study or in-service training. Research into how the discipline can more effectively deal with the program is critical to this problem.

I have some concern, Mr. Chairman, with, as I interpret it, the definition that Mr. Black gave before this subcommittee of the University Affiliated Center as a hospital substitute. We think this is one thing that it is not. It has moved into the area of ambulatory care, the availability of services within the community, the training of people who can work in the communities. This, then, brings to mind the concerns that many of us have in the entire health field—how we are going to more effectively apply those things that we know, and get equal distribution of the impact.

Dr. Roger Egeberg has referred to the health area as the last of the cottage industries. I am afraid that we must in a sense agree with him. We think that within health there is a critical need for a major reorganization of the kinds of services, the availability of services, the opportunity for utilization of services. We feel that the spectrum of services with which the University Affiliated Centers are concerned may represent a model that can be very helpful to the health of the profession generally.

The construction requirements are essential if additional areas in the country are to have the opportunity to develop programs to meet the need for people who can work in this area in relation to the needs of communities that are just beginning to develop programs for the retarded. Again, the basic operational support moneys that are mentioned are vital, and will be extremely important to the universities in the developing of programs.

The single project grant approach, as mentioned in the administration bill, would be extremely dangerous for the universities which have made a major commitment—in most cases on a 20-year basis—for the operation of these programs. We are indeed concerned that many of the roles of professional people need to be reevaluated in terms of their educational training to most expeditiously carry out these projects, and from this point of view, we think the junior colleges or 2-year colleges may be a very important source for this type of personnel that the universities will concern themselves with, as well as their involvement with the community.

(Dr. Gibson's prepared statement follows:)

STATEMENT OF DR. WILLIAM M. GIBSON, PRESIDENT, ASSOCIATION OF DIRECTORS AND ADMINISTRATORS, UNIVERSITY-AFFILIATED CENTERS

Mr. Chairman, Members of the Subcommittee. It is indeed a privilege to appear today to testify before the Subcommittee on Public Health and Welfare.

This testimony is given on behalf of the University-Affiliated Centers for the training and education of persons anxious to work with the mentally retarded and developmentally disabled. Accompanying me today is Dr. Harrie R. Chamberlin, Director of the University-Affiliated Center at the University of North Carolina in Chapel Hill. Together we represent the Association of Directors and Administrators of nineteen approved and funded universities, ten universities in

the final stages of planning and program development and approximately thirty other universities with a continuing interest and in varying stages of planning. (A full list of our membership is appended).

This organization feels honored to have the opportunity to lend its support for the adoption by the House of Representatives of H.R. 14237 (Rogers, Florida; Jarman, Oklahoma; et al), (S. 2846) which we view as a progressive bill. This proposed legislation reflects the sensitivity which we share for the development of community-based facilities for the mentally retarded and developmentally disabled.

Parents of the retarded have come to expect from our society the opportunity to have the management of their children's problems attended to within the existing community structure. Hundreds of community mental retardation centers will be needed to bring the health, education and welfare services near those who need them. At present 242 community facilities have been approved under Part C Title I of Public Law 88-164, a laudable achievement for the architects of the community care concept. The logical extension of this effort is embraced in Title I of H.R. 14237 (S. 2846).

It is our feeling that the number of community centers established to date has been too small and their location too sporadic.

The plight of the developmentally disabled has been amply documented by the President's Committee on Mental Retardation in its many publications. The only questions remaining are the degree of participation by federal, state and local interests and the required implementation for producing the appropriate numbers of professional personnel who can function to staff community-based facilities.

The legislation sponsored by Mr. Rogers and his co-signers in H.R. 14237 (S. 2846) deals effectively with both concerns. Under Title II are some amendments to Part B of the Mental Retardation Facilities Construction Act. These amendments take into consideration the need for the construction of additional University-Affiliated Centers which will provide training areas for the community-based centers throughout the nation. The enclosed map indicates sizable areas of the country that do not presently have functioning University-Affiliated Training programs.

Title II also contains a section designed to assist institutions of higher education to contribute more effectively to the solutions of the complex health, education and social problems of children and adults suffering from mental retardation. Grants authorized for administering and operating demonstration facilities and interdisciplinary training programs will be critical to the universities who have undertaken a twenty-year commitment to the operation of such training programs. Approval of this legislation would allow for the effective operation of these programs and a wider spectrum of training personnel from each facility. Universities that do not require construction will require some administration and operating moneys to generate interdisciplinary training programs.

At present there are seven completed University-Affiliated Centers, two with construction partially completed and ten where construction is in progress. The Subcommittee may be pleased to learn that 646 trainees have been involved in University-Affiliated Center programs in the past year. The potential for training in the centers is roughly twice this number and full training capacity of these centers to be reached by 1974 will be approximately 2,750 individuals per year. University-Affiliated Centers are educating twice as many other person to the needs of the mentally retarded and developmentally disabled by in-service and community education contributions. The largest numbers are having their education expanded by some experience in course-work and exposure to the problem of mental retardation (27,000 by 1974).

The organization of Directors and Administrators of the University-Affiliated Centers, the Secretary's Committee on Mental Retardation, Federal government agencies given funding authority in this area, the National Association for Retarded Children, and superintendents of state institutions share with us the concern that the nation develop the capacity to train appropriate numbers of persons to work with the mentally retarded and developmentally disabled. Title II of this legislation thus becomes critical in defining the intent of Congress that these programs be able to accomplish their ultimate goal. In contrast, the Staggers-Springer Bill H.R. 15160 also refers to the training needs for persons dealing with the mentally retarded but its language permits this to be interpreted and administered in a way that could lead to a great deal of vacillation in the support of programs previously defined by legislation to stimulate people toward the development of careers in the field of mental retardation.

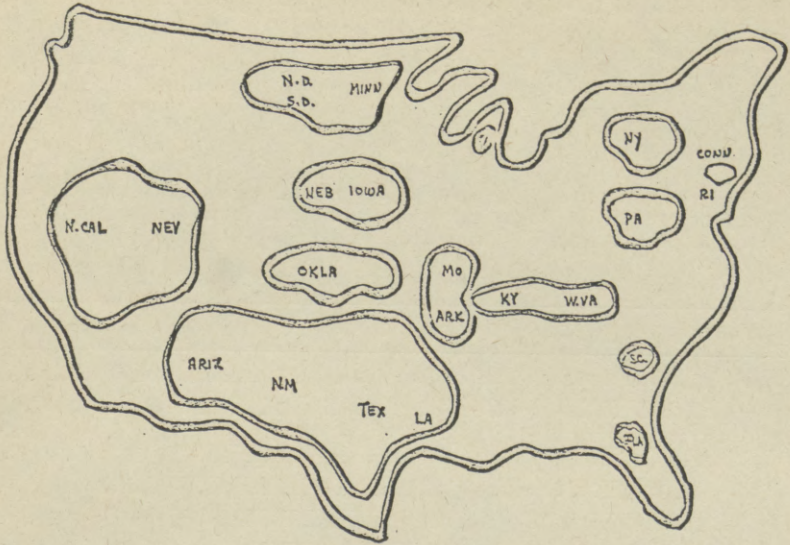
The interdisciplinary pattern of training with University-Affiliated Centers has shown, when combined with the university-community interaction necessary for these programs, that redefinition of the educational requirements of certain careers is timely. Teachers of the trainable retarded, persons designated as home visitors, other individuals who will be cottage parents or child development aides, persons concerned with vocational placement, are examples of persons where the two-year or junior college may be the appropriate educational setting.

In conclusion, I would like to thank you for this opportunity to appear before the Subcommittee to discuss with you our support of the legislation being introduced by Congressman Rogers of Florida and his co-signers. With the proposed legislation, we see the opportunity of extending and improving the Mental Retardation Facilities Construction Act to both more effectively care for the 3 to 5 percent of all Americans who are mentally retarded or developmentally disabled and to train the appropriate professional personnel needed to implement services.

PROGRAM DIRECTORS (OR CONTACTS), UNIVERSITY-AFFILIATED CENTERS

University	Name	City and State
Alabama	Andrew E. Lorincz, M.D.	Birmingham, Ala.
Do	Alfred A. Baumeister	Tuscaloosa, Ala.
Albert Einstein	Larry Taft, M.D.	New York, N.Y.
Arizona	David Wayne Smith, Ed. D.	Tucson, Ariz.
Arkansas	Roger B. Bost, M.D.	Little Rock, Ark.
Baylor	Winston C. Cochran, M.D.	Houston, Tex.
Boston	Allen C. Crocker, M.D.	Boston, Mass.
Do	Hugo W. Moser, M.D.	Waverley, Mass.
Brandeis	Nathan E. Sklar	Warwick, R.I.
Brown	Allen R. Menefee	Providence, R.I.
California	Thomas L. Neslon, M.D.	Irvine, Calif.
Do	Irvine Phillips, M.D.	San Francisco, Calif.
Do	George Tarjan, M.D.	Los Angeles, Calif.
Cincinnati	Jack H. Rubinstein, M.D.	Cincinnati, Ohio.
Colorado	Harold P. Martin, M.D.	Denver, Colo.
Connecticut	John Crawley, Ph. D.	Storrs, Conn.
Duke	M. R. project director	Durham, N.C.
Georgetown	Robert J. Clayton, M.D.	Washington D.C.
Georgia	Andrew L. Shotick	Athens, Ga.
Do	James D. Clements, M.D.	Atlanta, Ga.
Idaho	Donald F. Kline, Ph. D.	Pocatello, Idaho.
Indiana	Milton Wisland, Ph. D.	Bloomington, Ind.
Do	Morris Green, M.D.	Indianapolis, Ind.
Institute of Logopedics	Charles W. Wurth	Wichita, Kans.
Iowa	R. R. Rembolt, M.D.	Iowa City, Iowa.
Johns Hopkins	Frederick Richardson, M.D.	Baltimore, Md.
Kansas	Richard L. Schiefelbusch, Ph. D.	Lawrence, Kans.
Kentucky	Vernon L. James, M.D.	Lexington, Ky.
Louisiana State	Merle F. Warren, Ed. D.	Baton Rouge, La.
Do	George R. Meneely, M.D.	New Orleans, La.
Louisville	Bernard Weiskopf, M.D.	Louisville, Ky.
Marquette	J. C. Peterson, M.D.	Milwaukee, Wis.
Miami	Samuel T. Giammona, M.D.	Miami, Fla.
Michigan	Julius S. Cohen, Ed. D.	Ann Arbor, Mich.
Minnesota	John A. Anderson, M.D.	Minneapolis, Minn.
Mississippi	Jerry H. Robbins	University, Miss.
Missouri	Rodman P. Kabrick, Ph. D.	Columbia, Mo.
Nebraska	Paul Pearson, M.D.	Omaha, Nebr.
Newark State College	Edward LaCrosse, Ed. D.	Union, N.J.
New York	Margaret Giannini, M.D.	New York, N.Y.
North Carolina	Harrie R. Chamberlin, M.D.	Chapel Hill, N.C.
Ohio State	William M. Gibson, M.D.	Columbus, Ohio.
Oklahoma	Logan Wright, Ph. D.	Oklahoma City, Okla.
Oregon	Robert H. Mattson, Ed. D.	Eugene, Oreg.
Do	Leroy O. Carlson, M.D.	Portland, Oreg.
Pennsylvania State	William R. Carriker, Ed. D.	University Park, Pa.
Purdue	Earl J. Heath, Ed. D.	Lafayette, Ind.
Rutgers	Larry B. Silver, M.D.	New Brunswick, N.J.
Southern California	Richard Koch, M.D.	Los Angeles, Calif.
Southern Florida	Calvin M. Pinkard, Jr., Ph. D.	Tampa, Fla.
St. Louis	Allan Barclay, Ph. D.	St. Louis, Mo.
Tennessee	Robert G. Jordan, M.D.	Memphis, Tenn.
Texas	Charles W. Daschner, Jr., M.D.	Galveston, Tex.
Texas Women's	Ted W. Booker, Ph. D.	Denton, Tex.
Tufts	Marshall B. Kreidberg, M.D.	Boston, Mass.
Tulane	Robert C. Heath, M.D.	New Orleans, La.
Utah State	Oral L. Ballum, Ph. D.	Logan, Utah.
Vanderbilt	Donald J. Stedman, Ph. D.	Nashville, Tenn.
Virginia	Jack R. Gallagher	Charlottesville, Va.
Washington	Robert Deisher, M.D.	Seattle, Wash.
Western Reserve	Jane Kessler, Ph. D.	Cleveland, Ohio.
Wisconsin	Rick Heber, Ph. D.	Madison, Wis.
Yale	Albert J. Solnit, M.D.	New Haven, Conn.

AREAS NOT COVERED BY VACO'S INTERSTATE CAPACITIES - 1970



Dr. GIBSON. I would like to call on Dr. Chamberlin, Mr. Chairman, if I may, just for a moment, to indicate to you some of the input.

Mr. ROGERS. Thank you.

STATEMENT OF DR. HARRIE R. CHAMBERLIN

Dr. CHAMBERLIN. Mr. Chairman, members of the subcommittee, I wish to speak very briefly about the picture in North Carolina as I see it. As the director of the University Affiliated Center for the Mentally Retarded at the University of North Carolina in Chapel Hill, I have found it an exciting experience to observe that our program, which is now becoming productive, is beginning to have an impact on the State. It is our hope that we will be allowed to grow to a point at which that impact will not only be greater within North Carolina, but may eventually extend into South Carolina and southern Virginia as well, areas where, as you know, there are no university affiliated centers.

In North Carolina our center is at the hub of 12 developmental evaluation clinics, strategically placed throughout our predominantly rural State, and also interacts with two new regional centers for the retarded now under development. In this position we find ourselves not only a center for receiving referrals of especially complicated cases, but, more important, we are a source of well-trained professional manpower, representing a variety of disciplines which share in the evaluation and management of the mentally retarded. Many of these professionals, not only trained in depth within their own discipline but highly experienced in the combined interdisciplinary approach, move out from Chapel Hill to fill positions in the State's evaluation clinics and regional centers, thus bringing expert help to local areas. These individuals, in addition, are trained to promote programs of prevention and high risk screening, so that early detection and prompt

initiation of management programs can eventually become part of the approach at the community level. As Mr. Rogers has already stated so well, this approach can eventually save large amounts of both Federal and State funds. All of us are well aware that an infant or child who can be prevented from becoming a custodial problem, by early detection and the prompt application of appropriate treatment techniques, may represent a saving to society over its lifetime of \$150,000 to \$200,000. A similar saving can result from complete prevention, through the use of appropriate genetic counseling or some of the new methods of prenatal diagnosis.

I would also like to speak briefly about the interaction between our university affiliated center and the interagency council on mental retardation which the Governor has established to develop and administer our State mental retardation plan. Our experience indicates that the kind of professional expertise available in a university affiliated center can be of tremendous help to such a council, which is charged with the formulation and coordination of programs for the retarded on a statewide basis. In North Carolina four members of the staff of our university affiliated center play significant roles in this State council. I feel that I have been fortunate, as chairman of one of its three primary committees and as a member of its steering committee, in having the opportunity to gain a clear picture of what is being accomplished and to see how well these members of our university affiliated center staff have contributed to the council's effectiveness. In the area of prevention, for example, we have shared in the establishment of an advanced form of statewide biochemical screening and in the establishment of a statewide program to minimize the serious problem of child abuse and neglect. In the field of education, members of our university affiliated center staff have played a leading role in working toward State legislation which requires sophisticated, indepth evaluation of all children being assigned to special education classes, in part to be certain that youngsters who are merely socioculturally deprived are not branded for life as being mentally retarded on the basis of superficial testing. Through the council, university affiliated center staff are also working to establish positions for personnel who would have the responsibility for maintaining liaison between the State's developmental evaluation facilities and local school districts, so that the recommendations made by the staff of these facilities can be thoroughly useful and meaningful to special education teachers. It is clear that the group charged with interagency mental retardation planning in any State which lacks a university affiliated center would benefit greatly by the establishment of such a center in that State.

In conclusion, I wish to say that we are most appreciative of your efforts in advancing this legislation and of the fine way in which it reflects the needs of the developmentally disabled. I am happy to have had the opportunity to speak to you in its support.

Mr. ROGERS. Thank you very much. We appreciate it.

What is done to screen the schools for mentally retarded; anything?

Dr. CHAMBERLIN. I happen to have been chairing a committee of the North Carolina Council on Mental Retardation which is working vigorously on the upgrading of such a screening program. All of us would like to see adequate screening of all children established long

before they have contact with the schools, and we are working toward this, but at this stage we must start at the point at which we have a handle to reach every child, which is when they first become the responsibility of a preschool or school program. As I mentioned earlier, we are working on State legislation which would allow indepth evaluation of all children whose performance is of concern to their teachers, and would require such an evaluation for all those being considered for a special education class. Such evaluations involve physicians, local public health nurses, local welfare workers, and not only highly qualified psychologists but subprofessional personnel who work under the close supervision of these psychologists. This is one of the areas in which I believe people at the junior college level can make a great contribution, under the guidance of skilled psychologists. The study of any child being assigned to a special education class should be done with care and we feel that for many children this is not being accomplished adequately in the majority of States.

Mr. ROGERS. If you could let us have for the record the number of university affiliated centers.

Dr. GIBSON. It is in our prepared statement, sir.

Mr. ROGERS. It is in your statement, and do you project how many are trained at each center?

Dr. GIBSON. Yes, sir.

Mr. ROGERS. Specifically?

Dr. GIBSON. Specifically, not disciplines, we have not given you the disciplinary breakdown. Through the secretary's committee, Mr. Tadashi Mayeda, did a very extensive survey of university affiliated centers and perhaps Mr. Baxter might like to contribute the summary of this.

Mr. ROGERS. Well, I think that would be helpful to the committee and we will include that in our committee files as soon as it is finished.

Are you doing research at the university center?

Dr. GIBSON. We are doing a great deal of research, but not in the basic field of so-called hard disciplines. Our research is primarily interaction and observation types of research—research into the mobilization of resources, expeditious handling of problems, prevention—this type of research is definitely ongoing, sir.

Mr. ROGERS. If you could let us have for the record, examples of this, I think it would be helpful to let us know.

(The following letters and attachments were received for the record:)

THE OHIO STATE UNIVERSITY,
MENTAL RETARDATION TRAINING PROGRAM,
Columbus, Ohio, June 12, 1970.

Congressman PAUL G. ROGERS,
House Subcommittee on Public Health and Welfare,
Rayburn House Office Building, Washington, D.C.

DEAR CONGRESSMAN: Thank you for inviting Dr. Harrie R. Chamberlin and myself to appear before your Sub-Committee on behalf of the Association of Directors and Administrators of the University-Affiliated Centers for the Mentally retarded. In order to complete our testimony, I wish to respond briefly to two requests made by the Sub-Committee.

1. Directors of the University-Affiliated Centers contributed information to a report prepared by Mr. Tadashi Mayeda for the Secretary of HEW's Committee on Mental Retardation. Since this is an Administration document, I respectfully suggest that you request a copy from the Secretary. Since it is a lengthy document, you may wish to request only the summary section.

2. A night letter has been sent to the Directors of the approved and functioning University-Affiliated Centers for the purpose of obtaining a list of research activities under way. We would expect to have this information prepared to forward to you by June 15. The response to this appropriate request by the Sub-Committee should indicate the degree to which research directed to the prevention and more effective management of the mentally retarded and developmentally disabled is being dealt with in the functioning Centers.

The Center Directors concur with the comment by Congressman Rogers regarding the hazard of fighting inflationary tendencies by reducing appropriations. It is our feeling that the University-Affiliated Centers, if allowed to reach their maximum potential, will more than pay for themselves in the reduction of overall costs in dealing with the mentally retarded and developmentally disabled through the effective operation of community-based Centers.

Sincerely,

WILLIAM M. GIBSON, M.D., *Director.*

THE OHIO STATE UNIVERSITY,
MENTAL RETARDATION TRAINING PROGRAM,
Columbus, Ohio, June 17, 1970.

Congressman PAUL G. ROGERS,
*House Subcommittee on Public Health and Welfare,
Rayburn House Office Building, Washington, D.C.*

DEAR CONGRESSMAN: The accompanying packet of materials represents the response from the University Affiliated Centers to your question regarding the nature, variety, and extent of research taking place in relation to these programs.¹ It is my hope that the material will indicate to you the concerns that the University Affiliated Centers have in reducing the problems of the mentally retarded and developmentally disabled.

Thank you for the opportunity to appear before you. If any questions arise from this submission, I would be pleased to attempt to answer them on behalf of the University Affiliated Centers.

Sincerely,

WILLIAM M. GIBSON, M.D., *Director.*

THE OHIO STATE UNIVERSITY, MENTAL RETARDATION TRAINING PROGRAM,
COLUMBUS, OHIO

RESEARCH PROJECTS

Paint Chip Study.—Undertaken in cooperation with Columbus Public Schools and Department of Health. Phase I completed, namely the procurement of paint chips from homes of pupils within a Model City area. Phase II in process, namely the analysis of paint chips for lead. In the next phases school and families will be informed of the presence or absence of lead and it is anticipated that intelligence and academic data will be collected to compare the children from lead-free homes with those from lead-present homes.

PKU Assessment.—Undertaken in cooperation with State of Ohio to determine the effectiveness of the early infant identification program.

Physical Therapy Study.—Demonstration project to establish the role of physical therapy in Public Health Nursing.

Early Education Project.—Study partially funded by U.S. Office of Education. Focused on stimulating 12-24 month infants with developmental disabilities in an effort to reduce subsequent retardation in functioning.

Survey of Institutional Residents.—In conjunction with New Jersey Division of Mental Retardation, a survey of levels of retardation among residents within a Center for profound and severe cases who had not been tested recently. Purpose was to determine if program changes and modification of individual prescriptions were in order.

Evaluation of UAC Training.—Development of procedures for regular data storage re: training, service and research activities of staff and students, with particular emphasis on interdisciplinary activities. The original instrument has

¹ EDITOR'S NOTE: Further responses received from the University Affiliated Centers will be placed in the committee's files.

been tried for a half-year and is being revised based on analysis of data obtained as well as personnel reactions.

Nutrition Project.—Study of children in day care centers to relate aspects of nutrition and development.

Family Stress and Retardation.—Doctoral study focused on families with pre-school children. Analysis will consider socio-economic factors as related to stress of raising a retarded child within the home.

Comparative Study of Retarded Patient Loads.—Survey of types of retarded children which are seen at various clinics within Children's Hospital and the UAF Center.

Case Finding Projects.—In conjunction with the Model Cities program, a joint effort at locating retarded children within high risk families.

Audio-Visual Demonstration.—Development of A-V presentation of behavior of pre-school retarded and non-retarded children as a teaching tool. Assessment of the technique will follow.

The McDonald Family.—A genetic survey of a multihandicapped family through four generations.

JOSEPH P. PARNICKY,
Chairman, Standing Committee on Research.

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UNIVERSITY OF ALABAMA, CENTER FOR DEVELOPMENTAL AND LEARNING DISORDERS

Following is a list of major research projects being carried out in our center. Six professors and 20 graduate students are involved in these projects, ranging from 25% to full-time.

- (1) Psycholinguist processes in mentally retarded and culturally deprived children.
- (2) Stimulus factors in verbal learning of mental retardates.
- (3) Stereotyped movements in severely retarded patients.
- (4) Memory processes in mentally retarded and deprived children.
- (5) Language development in mongoloid preschoolers.
- (6) Information processing strategies in educable mental retardates.
- (7) Imitation procedures in developing self-help skills.
- (8) Motivational factors in the performance of retarded subjects.

Since our center opened in September, 1968 we have published approximately 50 articles in professional journals and books. Most of this research effort is supported by small grants from the university and from the Psychology Department. We have one research grant (about \$25,000) from NICHD.

ALFRED A. BAUMEISTER, Ph.D.,
Director.

* * *

THE UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL, CHILD DEVELOPMENT INSTITUTE, BIOLOGICAL SCIENCE CENTER, DIVISION FOR DISORDERS OF DEVELOPMENT AND LEARNING

The following is a list of research projects, ongoing, completed, and published, and theses and dissertations that have been carried out through our center.

RESEARCH PROJECTS IN THE D.D.D.L.

1. Relationships Among Physical and Psychological Variables During Pregnancy, Complicating of Pregnancy, Labor, and Delivery, and the Behavioral Status of the Newborn Infant. Marilyn T. Erickson, Ph.D.
2. The Effects of Remedial Reading Programs on Rate of Learning to Read. Marilyn T. Erickson, Ph.D.
3. The Use of the Weschler Intelligence Scale for Children as a Diagnostic Instrument for Learning Disabilities. Marilyn T. Erickson, Ph.D.
4. Screening Tests as Predictors of Mental Retardation and Learning Disabilities. Marilyn T. Erickson, Ph.D.
5. Sibling Order and Sex Differences in Environmental Stimulation of Children. Marilyn T. Erickson, Ph.D.
6. Perinatal Complications and Dental Morphology in Retarded Children. Marilyn T. Erickson, Ph.D., and William S. Goodwin, D.D.S. (graduate student in pedodontics).
7. Performance of Mildly Retarded Children Under Delayed Reinforcement Conditions. James R. Frazier, Ph.D.
8. The Usefulness of Four Diagnostic Instruments in the Early Diagnosis of Learning Disorders. Frances Campbell, Ph.D., and Nancy M. Johnson, Ph.D.

9. The Effects of a Structured, Sequential Perceptual Development Program on Culturally Disadvantaged Preschool Children. David L. Lillie, Ed.D.
10. Characteristics of Psychotic Children Referred to an Interdisciplinary Clinic. Raymond Schmitt, M.D.
11. Psychological Effects of Retarded Children on Their Families. Raymond Schmitt, M.D.
12. REM Sleep of Children with Perceptual-Motor Deficits. Carolyn S. Schroeder, Ph.D.
13. The Predictive Validity of the Bayley Infant Scales of Development. Marilyn T. Erickson, Ph.D., Nancy M. Johnson, Ph.D., and Frances Campbell, Ph.D.
14. The Relationship Between the Denver Developmental Screening Test and the Bayley Infant Scales of Development for Retarded Children. Marilyn T. Erickson, Ph.D., and Delores W. Estes, R.N., M.A.
15. Investigation of Two Processes in Language Development Through a Test of Auditory-Syntactical-Sequential Memory. Sandra C. Barrie, M.A.
16. The Morphogenesis of Hydranencephaly. James Halsey, M.D., Normal Allen, M.D., and Harrie R. Chamberlin, M.D.
17. MMPI Profiles of Parents of Young Retarded Children. Marilyn T. Erickson, Ph.D.
18. Modification of Multiple Behavior Problems with the Mother as Therapist. Marilyn T. Erickson, Ph.D.
19. Relationships Among Scores on Infant Tests for Preschool Children with Developmental Problems. Marilyn T. Erickson, Ph.D., Nancy M. Johnson, Ph.D., and Frances Campbell, Ph.D.
20. Relationship of Speech Detection Thresholds (sound field) to Pure Tone Audiometric Configuration in the Preschool Child. F. X. Calvin Knobloch, Ph.D.
21. The Effect of Tangible Reinforcement on the Learning and Retention of Programmed Material in Academically Retarded Children. James R. Frazier, Ph.D.
22. Beginning to Learn : Fine Motor Skills. David L. Lillie, Ed.D.
23. Beginning to Learn : Perceptual Skills, David L. Lillie, Ed.D.
24. Decision Conflict in Children in a Risk Situation. Carolyn S. Schroeder, Ph. D.
25. Chronic Deceberate State in Infancy : Neurologic Observations in Long Surviving Cases of Hydranencephaly. James Halsey, M.D., J. Normal Allen, M.D., and Harrie R. Chamberlin, M.D.
26. MMPI Comparisons Between Parents of Young Emotionally Disturbed and Organically Retarded Children. Marilyn T. Erickson, Ph. D.
27. Lingual and Labial Movements of Pierre-Robin Syndrome Patients Treated by the Beverly Douglas Procedure. M. Carole Levinson, M.C.D.
28. The Effects of Motor Development Lessons on Mentally Retarded Children. David L. Lillie, Ed. D.
29. A Method for Frequent Assessment of Symptomatology During Pregnancy. Marilyn T. Erickson, Ph. D.
30. Intelligence : Prenatal and Preconceptual Environmental Influences. Marilyn T. Erickson, Ph. D.
31. The Predictive Validity of the Cattell Infant Intelligence Scale for Young Mentally Retarded Children. Marilyn T. Erickson, Ph. D.
32. Preschool for the Mentally Retarded. David L. Lillie, Ed. D.
33. Parental Evaluation of Patient Services at a University Affiliated Facility. Elaine L. Goolsby, M.S.W.
34. An Intervention Program for the Prevention of Perinatal Complications. Marilyn T. Erickson, Ph. D.

STUDENT PAPERS

1. Attitudes of Parents of Retarded Children Concerning Availability of Recreational Facilities. M.A. thesis, Recreation.
2. A Conceptual Framework for Evaluating Families with a Mentally Retarded Child. M.S.W. thesis, School of Social Work.
3. Amount of Information Derived by Parents at the Interpretive Conference. M.A. thesis, School of Public Health.
4. Effects of a Child's Handicap on the Family as a Social System. Ph. D. dissertation, Department of Sociology.
5. The Effectiveness of Videotapes Feedback as a Training Procedure for Teachers of Handicapped Preschool Children. Department of Special Education.
6. A Study of the Rapid Growth of the U.A.F. Staff as Reflected in Interaction Among Its Personnel. Ph. D. dissertation, Department of Sociology.

7. The Role of the Nurse in Identifying the Minimally Brain Damaged Child. M.A. thesis, School of Public Health.
8. The Role of Eye Contact in Infant Conditioning. Ph. D. Dissertation, Department of Psychology.

GEORGE G. WILLIAMS, Jr., *Administrator*.
HARRIE R. CHAMBERLIN, M.D., *Director*.

* * *

UNIVERSITY OF OREGON MEDICAL SCHOOL, CRIPPLED CHILDREN'S DIVISION,
PORTLAND, OREG.

The following is a list of clinical research projects in the University of Oregon Medical School University Affiliated Center Program.

- "Study of the University of Oregon Medical School, Multi-Discipline Clinic"—for the mentally retarded and handicapped children—demographic data, effectiveness of team approach, and parent education.—Garner, Ann M., Ph. D.; Carlson, Leroy, M.D.; Justice, R. S., D.S.W.; Williams, Chris, M.D.; Carson, Wilma, M.D. (Psychology, Pediatrics, Social Work).
- "An Evaluation of Ability of the Nasopharynx (upper throat) to Compensate by Learning How to Speak Normally with a Short Palate."—Blakeley, R. W., Ph. D. (Speech Pathology).
- "A Scale for Measurement of Growth and Development."—Boyd, R. D., Ph. D (Psychology).
- "A Study of the Properties of Speech that Serve to Identify the Sex of the Speaker."—Coleman, R., Ph. D. (Speech Pathology).
- "Investigation of Family Interactions in Families in Which a Child Has Juvenile Diabetes."—Garner, Ann M., Ph. D. (Psychology).
- "Evaluation of Change in Parent-Child Interaction Where the Child is Mentally Retarded, as a Result of Individual or Group Treatment of Mothers by Means of Behavior Modification Techniques."—Garner, Ann M., Ph. D.; Terdal, Leif, Ph. D. (Psychology).
- "Primary Tooth Morphology."—Gullikson, J. S., D.D.S. (Dentistry).
- "Determining for a Population of Physically Handicapped Children and Their Parents the Common Behavior Patterns Present in all Problem Management Situations."—Hand, C., Ph. D. (Psychology).
- "A Study of Verbal Reciprocity Patterns Between Normal Child-Normal Mother Pairs, and Retarded Child-Normal Mother Pairs."—Hegrenes, Jack R., M.S., M.A.; Marshall, Nancy, Ph. D. (Social Work, Speech Pathology).
- "A Follow-up Study of Families with Children Labeled Mentally Retarded (Families are Evaluated by Multidisciplinary Clinic)."—Justice, R. S., D.S.W. (Social Work).
- "A Study of Foster Parents of the Retarded."—Justice, R. S., D.S.W. (Social Work).
- "How Personal, Private, and Community Resources are Used by Natural Parents of Retarded Children."—Justice, R. S., D.S.W. (Social Work).
- "A Comparative Study of Educationally Handicapped, Trainable Mentally Retarded and Normal Children in a Public School System."—Justice, R. S., D.S.W. (Social Work).
- "A Comparative Study of a University Specialty Clinic Population and the Population of the Community it Serves."—Justice, R. S., D.S.W. (Social Work).
- "A Study of Metabolic Products in the Urine of Mentally Retarded Children."—Lis, E., Ph. D.; Cunningham, Lillian, M.P.H. (Nutrition).
- "An Epidemiologic Survey of Congenital Heart Disease in Oregon."—Menashe, Victor D., M.D. (Pediatrics).
- "A Study of the Recurrence of Congenital Heart Disease in Families in which one of the Parents has Congenital Heart Disease."—Menashe, Victor, D., M.D. (Pediatrics).
- "An Attitudinal Study Using Semantic Differential to Evaluate Feelings People Have About Certain Dental Concepts."—Sterling, E. S., D.D.S. (Dentistry).
- "The Oral Discrimination of Geometric Forms by Children."—Weiss, Curtis E., Ph.D. (Speech Pathology).
- "The Application of Electroencephalography to the Measurement of Hearing in the Infant and Young Child Under the Usual Age Level for Voluntary Audiometry."—Young, N. B., Ph.D. (Speech Pathology & Audiology).

- "Investigation of Patients with Inherited Metabolic Defects to Determine the Nature of Gene Product (Enzyme or Structural Protein) Abnormality."—Bigley, R. H., M.D. (Medical Genetics).
- "Detection of Chromosomal Abnormalities and Heritable Minor Chromosome Variations in Clinic and Hospital Patients and Their Families."—Hecht, F., M.D. (Medical Genetics).
- "Pilot Computer Chromosome Registry to Store, Recall, and Analyze Cytogenetic Data."—Hecht, F., M.D. (Medical Genetics).
- "Studies of Chromosome Breakage in Ataxia-Telanglectasia and Other Diseases."—Hecht, F., M.D. (Medical Genetics).
- "Search for Selection in Human Blood Groups."—Juberg, R. C., M.D., Ph.D. (Medical Genetics).
- "A Study of a Familial Form of Epilepsy and Mental Retardation."—Juberg, R. C., M.D., Ph. D. (Medical Genetics).
- "Investigation of Metabolic Defects (Birth Defects) Associated With Mental Retardation."—Copple, Peggy, M.D.; Buist, Neil R., M.D. (Pediatrics).
- "EEG Studies in Mental Retardation."—Copple, Peggy, M.D. (Pediatrics).
- "Electroencephalographic Studies in Newborn and Young Infants and Subsequent Development."—Engel, R. C., M.D.; Milstein, Victor, Ph.D.; Seaman, G. V., Ph.D. (Pediatrics, Neurology, Biochemistry).
- "The Evaluation and Inheritance of Clinical Diseases in Children."—Lovrien, Everett W., M.D. (Medical Genetics).
- "A Device for Heel Cord Stretching."—MacFarlane, David W., M.D. (Pediatrics).

LEROY O. CARLSON, M.D.,
Associate Professor of Pediatrics.

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UNIVERSITY OF COLORADO MEDICAL CENTER, JOHN F. KENNEDY CHILD DEVELOPMENT CENTER, DENVER, COLO.

The following are several brief descriptions of research studies being conducted at our center. These projects are in addition to routine follow-up studies on patients seen at our Center plus several individual projects involving Battered Children, Lay and Professional Attitudes toward various Developmental Disabilities, Child Attitudes toward Dentists, Group Intake, and others. As you know, our primary focus is on service and training; therefore, most of our research is related to this focus.

JOHN H. MEIER, Ph. D.,
Associate Professor in Pediatrics
and Clinical Psychology.

SPEECH AND HEARING

The speech pathologist does routine pure-tone audiometric screening on all new patients accepted at the Center and refers any cases of suspected hearing loss or impairment to the Otolaryngology Department for a thorough audiologic study. Patients who require speech therapy are temporarily treated by the Center's speech therapist until another placement and/or home training procedures have been established. Long-term therapy is instituted for certain children selected for their demonstration and training value.

REHABILITATION PROGRAM

At the present time, the rehabilitation staff consists of two half-time physical therapists, two half-time occupational therapists, two half-time speech therapists, and one recreational therapist. All of these therapists are working under the direct supervision of one of the Center staff pediatricians. They hold joint positions with the JFK Center and the Department of Physical Medicine and Rehabilitation. Four half-time and one full-time position are funded through an RT 10 (Research and Training) grant awarded to the Department of Physical Medicine and the JFK Center by the Social and Rehabilitation Service of the Department of Health, Education, and Welfare (the other two half-time salaries being supplied by our Children's Bureau Service Grant). This grant was awarded for the purpose of researching treatment methods in preschool and young elementary-age school children with perceptual handicaps. Many of

the Center's patient population makes up the group of children in this research-treatment group.

All of these therapists evaluate children diagnostically as part of our clinical operations. Muscle assessment, reflex development, perceptual testing, speech and language assessment, diagnostic categorization of neuromuscular disorders are some of the diagnostic services they provide our children. While usually interwoven with the diagnostic services, the therapists routinely help in planning treatment programs for our children. This may include assistance in referral to community resources, including the Physical Medicine Department at Colorado General Hospital. More often, treatment is started and a home treatment program is prescribed and supervised through periodic visits. When neither of the above is available or appropriate, the therapists communicate with school teachers, public health nurses, nutritionists, etc., to help counsel them in a treatment mode or stance that they can take in working with these children. The therapists attend case reviews, team meetings, and interdisciplinary seminars.

Inasmuch as five of these therapists, in addition to working half time in this Center, work half time in the Physical Medicine Department at Colorado General Hospital, during their working time at this latter location, they frequently see patients for diagnostic or treatment referred by the JFK Center. This most often occurs when their time and the referral population are in dissonance, or when the treatment needs are quite time consuming and chronic and can only be met through their job responsibilities in the Physical Medicine Department. However, since these professionals are working half time in our Center and are available at staff meetings and case reviews, they are able to report on their findings or treatment progress in person in an interdisciplinary fashion.

LABORATORY SERVICES

Through the Stolinsky Laboratories and the Pediatric Microchemistry Labs, each patient routinely gets a urinalysis, complete blood count, serum and urine amino acid chromatography, and copper oxidase procedures. More elaborate procedures, such as organic acid chromatography, are now included in routine workups. The laboratories also make available screening services for other family members. In addition, through Children's Bureau special project #452, buccal smears, dermatoglyphics, and complete chromosome analyses may be obtained. Routine laboratory services are of course available to practitioners and other clinics in the region to assist in the workup of the retarded child. It must also be stressed that screening procedures with the laboratories are also capable of highly sophisticated analytical procedures for diagnosis, including those from a privately donated mass spectroscopy laboratory.

EARLY CHILDHOOD SPECIAL EDUCATION DEMONSTRATION LABORATORY

This project is designed to train early childhood special educators to deal with exceptional children in the regular preschool program or regular primary classroom. It serves experienced teachers, school system inservice teacher trainers and college preservice teacher trainers. In order to insure a meaningful practicum experience, a demonstration preschool laboratory has been established as an integral part of the John F. Kennedy Child Development Center. Trainees participate in all activities at the JFK Center, which is an interdisciplinary evaluation and treatment program for children who have various developmental disabilities. Extensive training programs are conducted for high level post graduate personnel in audiology, dentistry, education, nursing, nutrition, occupational therapy, pediatrics, physical therapy, psychiatry, psychology, recreational therapy, social work, and speech therapy. All trainees, therefore, learn about the complexities of normal and abnormal child development from many points of view.

The EPDA trainees focus on designing and implementing individualized educational programs and for children with specific deficits who represent the handicaps found in regular classrooms, particularly in rural and ghetto-urban areas. Particularly effective and generalizable programs are field-tested, packaged, and disseminated under other EPDA and related auspices. The trainees participate in all four classroom programs, which represent four distinct models of early childhood education: 1) The Bereiter-Engelmann's academic preschool; 2) Sprigle's learning to learn program; 3) Hewett's engineered classroom; and 4) the Nimnicht-Meier New Nursery. Promising and tested procedures and

materials for early preventative intervention with infants and mothers are also learned. Trainees learn to use new media and proven techniques for effective training of others in order to insure the multiplier effect of training teacher trainers.

REMOTE MICROTRAINING OF EARLY CHILDHOOD SPECIAL EDUCATORS

This EPDA project extends a pilot training model, developed as an NDEA Title XI Institute (1967-68), into a comprehensive early childhood training program. Using largely those materials and procedures which were most successful during the pilot institute, project staff guide the development of continuing inservice training for teachers and aides working with environmentally deprived and other educationally handicapped children. Each year six new teacher/aide teams from six additional locations receive three weeks of massed input followed by thirty-three weeks of distributed field practicums. The intensive input sessions familiarize the central teacher/aide teams with the unique training process and expose them to concentrated information regarding sociological, anthropological, medical, psychological, and pedagogical considerations necessary for assessing and dealing effectively with developmental disabilities in children. The first year of the EPDA project used a sequence of sixty-four previously validated written and filmed learning episodes comprising sixteen training units developed at the New Nursery School. Field-testing of eight new units developed at the JFK Child Development Center was also accomplished during the first year; these units focused on assessment of incipient learning disabilities and skills needed to prevent those from progressing. The second year of the EPDA project focuses on even younger children, developing and packaging infant curriculum for preventing many developmental disabilities. The central trainees, working in their own classrooms or child centers, videotape their efforts to implement the learning episodes, being critiqued by project staff. They also supervise and critique similar efforts of two additional participating teacher/aide teams in each respective satellite location. In subsequent years, the satellite teacher/aide teams become trainers of other teams, thus creating a multiplier effect. Continuing formative evaluation by program participants, project staff, and an independent evaluator influences annual program modifications. Each subsequent year adds new groups of trainees and new curriculum for field-testing or widespread dissemination after it is empirically validated.

INFANT STIMULATION PROJECT

Abstract

This program is being undertaken to find out whether systematic programs of stimulation in the first three years of life can enhance the cognitive development of children at risk for developing learning disorders. The risk factors of interest are neurological dysfunction and environmental deprivation, which taken together, account for 76% of the retarded population of the United States. Based on the assumption that intellectual deficits can be prevented in children at risk for socio-cultural or neurological reasons, it is our primary goal to develop a detailed curriculum of stimulation materials which can be easily communicated to mothers and non-professional aides. The purpose of this proposed investigation is two-fold: 1) to design specific preventive intervention programs for high-risk infants; and 2) to evaluate the effectiveness of such programs by comparing the later cognitive development of the research subjects with a group of matched controls.

Description of research proposed

The purpose of this program is to determine whether systematic programs of stimulation in the first three years of life can enhance the cognitive development of high-risk children. In addition to this basic question, a second one is concerned with the relative effectiveness of stimulation administered through day care programs vs. home programs which the parents are taught to administer. These questions can be posed statistically in the following experimental design, in which the factors manipulated are: 1) the treatment variable; 2) neurological status; and 3) home-based treatment vs. day care treatment. For each experimental group of 20 subjects, there is an equal number of controls matched in age, sex, parental education and income, and neurological status.

TABLE 1.—*The four experimental groups receiving stimulation programs*

<i>Neurologically normal</i>		<i>Neurologically high risk</i>	
<i>Home-based</i>	<i>Day-care</i>	<i>Home-based</i>	<i>Day-care</i>
La Junta, Colo.	Colorado	University	University
Parent-Child	Migrant	Hospital	Hospital
Center	Council	High-risk	High-risk
N=20	N=20	Nursery	Nursery
		N=20	N=20

Evaluation and follow-up

Since this program is concerned primarily with prevention of school failure through early stimulation with high-risk infants, it is mandatory that the research subjects be followed at least through the end of the first grade. In fact, the project could best be conceptualized as a longitudinal study of the effects of early intervention on infants at risk for developing learning problems. A schedule for testing and other evaluations will be followed carefully for both the experimental and the control groups. In addition to the formal evaluations, parents will be encouraged to keep anecdotal records in accordance with an outline provided. The staff making home visits will also be trained to observe for specific behaviors in subjects and other significant persons in the home environment. Since each learning episode in the stimulation curriculum has its own terminal behaviors, the level of mastery on these also serves as an index for evaluation.

The initial measures obtained for each subject will be Apgar scores; medical and neurological examinations; and prenatal and birth histories. At 6 months of age, each child will be given the Bayley Scales of Mental and Motor Development, which will be re-administered at 12 months, 18 months, and 30 months, and 48 months. At three years of age, prior to enrollment in a preschool program, all the children will receive a complete battery of tests, including the Bayley Scales, the Frostig Developmental Test of Visual Perception, and standardized speech, language, and neurological examinations. This same battery will be repeated at five years of age and again at 6½ to 7, which is roughly at the completion of the first grade. This "first grade" evaluation will also include achievement testing and teacher ratings.

Curriculum development

At this point in our research, it is essential that we "field test" and evaluate our stimulation materials and instructions in order to determine their suitability and effectiveness. We are planning to have the entire project funded and underway by July, 1970. Between now and then, it is our goal to refine the prescribed learning sequences for infants from birth to three years of age, and to "package" the instructions in pamphlets and brochures which will be attractive and understandable to parents. We also plan to use videotape as a medium for training both aides and mothers in the stimulation techniques which we are developing.

The Parent-Child Center in La Junta, Colorado, has agreed to serve as a vehicle for field testing the home stimulation programs for disadvantaged children. This Center has been in operation now for over a year, and has trained aides who make weekly visits to the homes of 60 families with at least one child under three. Dr. John Meier, Director of the John F. Kennedy Center, is a consultant to the La Junta Parent-Child Center, and has arranged for their staff to field test the effectiveness of our stimulation materials. These individuals, mostly non-professional aides, will be coming to Denver for a series of four two-day workshops in January and February to be trained in techniques of infant stimulation, which they will then teach to the disadvantaged mothers in their program.

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THE JOHNS HOPKINS UNIVERSITY SCHOOL OF MEDICINE,
DEPARTMENT OF PEDIATRICS, BALTIMORE, MD.

The following is a list of research projects carried out in our center.

1. Behavior modifications in the non-verbal child.
2. Controlled evaluation of Edison Responsive Environment.
3. Genetic analysis of dyslexia.
4. Evaluation of therapy of spina bifida.
5. Evaluation of PKU therapy.
6. Biology of mongolism.

7. Study of inborn errors of metabolism affecting the central nervous system.
8. Prenatal diagnosis of metabolic disorders.
9. Prenatal diagnosis of chromosomal disorders.
10. Systems analysis of interdisciplinary training.
11. Visual findings in the severe reading disorder.

(Mrs.) JUDITH LUKENSMAYER,
Secretary to Robert E. Cooke, M.D.

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UNIVERSITY OF OREGON, COLLEGE OF EDUCATION,
DEPARTMENT OF SPECIAL EDUCATION, EUGENE, OREG.

RESEARCH PROJECTS TAKING PLACE AT OUR CENTER AS A RESULT OF
UAC PROGRAM, EUGENE, OREG.

1. *Title: Northwest Regional Special Education Instructional Materials Center*

Principal Investigators: Wayne D. Lance, M. Stephen Lilly, James McLeod, Mary M. Rogers.

Purpose: (1) To acquire, evaluate, develop, and disseminate instructional materials for the use of students, teachers, and other professionals working with handicapped children; (2) to conduct applied educational research, aimed at improving instruction of handicapped children; (3) to give assistance to those engaged in education programs that involve exceptional children; (4) to supply information about materials, techniques, and research to those conducting work in field service projects; (5) to cooperate with and supplement existing regional, state and local programs.

2. *Title: An Investigation of Teacher Expectancies of Instructional Materials*

Principal Investigator: Boris E. Bogatz.

Purpose: (1) To investigate the effect of pre-conceived notions about the effectiveness of instructional materials; (2) to evaluate the SEIMC's procedures of material evaluation and information dissemination.

3. *Title: The Status of Teachers with Regard to Use of Instructional Materials in Teaching Academic Skills*

Principal Investigator: Stephen Lilly.

Purpose: (1) To determine the extent of teacher use of instructional materials for teaching in skill areas; (2) rate of use of specific instructional materials in selected academic areas; (3) availability of materials for teacher use; (4) teachers' knowledge of selected instructional materials; (5) sources of information used by teachers in learning about instructional materials; (6) materials purchasing procedures within school districts; (7) teachers' perceived power in influencing the purchase of instructional materials; (8) teachers' perceived needs in teaching in academic skill areas.

4. *Title: An Investigation of Teacher Expectancies of Instructional Materials*

Principal Investigator: Boris E. Bogatz.

Purpose: (1) To investigate the effect of pre-conceived notions about the effectiveness of instructional materials; (2) to evaluate the SEIMC's procedures of material evaluation and information dissemination.

5. *Title: Regional Resource Center for Handicapped Children*

Principal Investigators: Melton Martinson, F. Arthur M. Benson, James Crosson.

Purpose: (1) To provide direct services in the areas of individualized educational, diagnostic, and prescriptive procedures, techniques, and materials; (2) to develop and apply a theory of instruction with a behavioral orientation; (3) to transmit information and new procedures to key personnel in education; (4) to develop a teacher relevant theory of instruction.

6. *Title: Rehabilitation Research and Training Center in Mental Retardation*

Principal Investigators: Herbert J. Prehm, James E. Crosson, Philip L. Browning.

Purpose: (1) To conduct research related to the rehabilitation of the retarded; (2) to participate in both the pre-service and in-service training of persons interested in the area of mental retardation and who present any of the rehabilita-

tion professions; (3) to provide consultative services to state rehabilitation agencies.

7. *Title: Socio-Cultural Ecology of Upper Level Mental Retardation*

Principal Investigators: Arthur Perlin, Tom Conley.

Purpose: To survey the interpersonal dynamics and attitudinal settings related to the cultural deprivation process to which much mental retardation is attributed.

8. *Title: An Investigation into the Role of Stigma in Social and Personality Development of the Mentally Retarded: Methodological Study I*

Principal Investigator: Gordon Mullenix.

Purpose: To evaluate reported methodological strategies employed in studies of the techniques by which physically handicapped persons mediate the impact of their disability in social situations.

9. *Title: Perceptions of the Role of the Social Worker in Mental Retardation*

Principal Investigators: Herbert Prehm, Philip Browning, A. Fred Bahr.

Purpose: The purpose of this study is to clarify the role of the social worker in mental retardation.

10. *Title: Associative Motor Learning as a Function of Age and Intelligence*

Principal Investigator: Casper Ferneti.

Purpose: To investigate the performance of retarded and normal subjects through a visual presentation, motor response paired-associate learning task.

11. *Title: An Analysis of Situational Determinants of Work Adaptation in the Trainable Retarded*

Principal Investigators: James Crosson, Duane Youngberg, Sharon Hutton.

Purpose: To investigate, within the context of situational determinants of behavior, the relationship between personal-social and work setting adaptation. A particular focus will be the manner in which functional behavior-environment relations in extra work environments mediate adaptation in work settings.

12. *Title: Efficacy of Specific Pre-Placement Programming for Community Work Adaptation*

Principal Investigators: Oran Hutton, James Crosson.

Purpose: To determine the effectiveness of pre-placement programming (training in simulated work environments designed on the basis of specific analysis of proposed job placements) in facilitating the work adaptation of trainable retardates.

13. *Title: Analysis and Classification of Critical Response Variants Relative to Community Work Placement for the MR.*

Principal Investigators: Craig Peterson, James Crosson.

Purpose: This study constitutes a preliminary effort to clarify the extent to which discrete functional units are generalizable across a variety of task situations.

14. *Title: The Experimental Analysis of Vocational Behavior: Preliminary Analysis of Trainable Retardate Performances on an Electronically Dexned Chained Schedule.*

Principal Investigators: Owen White, James Crosson.

Purpose: It was the original intent of the investigators to explore certain questions regarding the use of social vs. extrinsic (token) reinforcers and interval vs. ratio schedules in the control of trainable retardate performances on a complex chain of behaviors. Due to the increased sensitivity of the programming and recording techniques over previous attempts to analyze chained behaviors, certain unexpected and interesting facets of the subjects' performances prompted the investigators to extend the first experimental condition in order to explore more fully the behavioral processes which obtained under the basic contingency of CRF-CHAIN. The effects of a simple discrimination (DISCRM CRF-EXT) were also explored briefly during the last few weeks of the project.

15. *Title: Development of Curriculum and Materials for Instructing Parents in Teaching Self-Help Skills to Preschool Multihandicapped Children*

Principal Investigators: Wayne Lance, James McLeod, Stephen Lilly.

Purpose: (1) To determine a basic core of self-help skills considered relevant for preschool multihandicapped children; (2) to determine which of these

skills are appropriate for parental instruction in a parent-child instructional setting; (3) to develop a program designed to instruct parents in teaching those selected skills to their multihandicapped children; (4) to field test, evaluate, and modify this program, including specialized materials; (5) to field test and evaluate modified program; (6) to package and disseminate the program through the network of SEIMCs and Early Education Center.

16. *Title: Center for Research and Demonstration in the Early Education of Handicapped Children*

Principal Investigators: Joseph Cobb, Gerald R. Patterson.

Purpose: (1) Determine relationship of observable classroom behavior to elementary school achievement; (2) develop intervention strategies to alter inappropriate classroom behavior.

17. *Title: An Experimental Approach to the Development of Intervention Programs for Factorially Homogeneous Groupings of Deviant Classroom Behavior*

Principal Investigator: Hill M. Walker.

Purpose: (1) To develop homogeneous groupings of maladaptive or deviant classroom behavior using behavioral assessment procedures and factor analytic techniques; (2) to experiment with intervention strategies measuring the efficiency and effectiveness of various procedures.

18. *Title: Perception of the Role of the Rehabilitation Counselor in Mental Retardation*

Principal Investigators: Philip Browning, Herbert Prehm, Juanita Robinson.

Purpose: The purpose of this study is to clarify the role of the rehabilitation counselor in mental retardation.

19. *Title: Perceptions of the Role of the Social Worker in Mental Retardation*

Principal Investigators: Herbert Prehm, Philip Browning, A. Fred Bahr.

Purpose: The purpose of this study is to clarify the role of the social worker in mental retardation.

20. *Title: Color-form preference and instructional techniques using color and form cues.*

Principal Investigator: Stephen Lilly.

Purpose: To determine if color-cue and form-cue instructional materials have differential effects on children dichotomized with regard to color form preference.

21. *Title: Development of a revised form of the Community Adaptation Schedule (CAS) for use with educable mentally retarded respondents*

Principal Investigators: Herbert J. Prehm, Philip L. Browning, Bert Romo, John deJung, Barbara Spence.

Purpose: To revise the Community Adaptation Schedule for use with the population of cultural-familial retarded.

22. *Title: Behavioral Assessment and Direct Intervention*

Principal Investigators: Barbara Bateman, George Sheperd.

Purpose: To construct and implement a variety of task ladders in social skills, self-help, and pre-academic areas for use with handicapped children. Each ladder will be composed of a sequence of subskills critical to the development of a larger terminal skill objective.

F. ARTHUR M. BENSON,

Associate Professor,

Clinical Services Director, Eugene U.A.C.

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INDIANA UNIVERSITY, MEDICAL CENTER, JAMES WHITCOMB RILEY HOSPITAL FOR CHILDREN, DEPARTMENT OF PEDIATRICS, INDIANAPOLIS, IND.

The following is a list of some of the research projects being carried out at our center.

1. Development of a curriculum of the mentally retarded which will enhance their self-concept.

2. Electroencephalographic and evoked potential studies in degenerative diseases of the brain leading to mental retardation.
3. Development of a group perceptual test for predicting school problems.
4. Development of a statistical technique to derive standard scores for the Bender-Gestalt visual motor test.
5. A study of language development in mildly retarded intercity black children.
6. A projected study to be done with Purdue University in standardizing an audio-visual group test for detecting perceptual problems in the mildly retarded.
7. A conjoint project with the Marion County Association for the Retarded, Indiana University (Bloomington), and Indianapolis School System to develop training project for teachers of the trainable retarded.
8. Analysis of data collected on 190 consecutive cases of "dyslexia."
9. We have helped a group at Elkhart develop a diagnostic center for mental retardation and learning problems.

MORRIS GREEN, M.D.,
Professor and Chairman.

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GEORGIA RETARDATION CENTER, ATLANTA, GA.

The following research projects are now underway at the Georgia Retardation Center:

1. Development of Neuro-Muscular research laboratory in cooperation with Department of Physical Medicine, Emory University School of Medicine.
2. "The Effect of an Integrated Physical Education Program on the I.Q. of the Educable Mentally Retarded" by Mr. Curtis Williams, University of Georgia.
3. "The Electrophysiological Correlates of Mental Functioning" by Dr. R. T. Osborne, University of Georgia.
4. "A Double Blind Comparison of Chlorzoxazone (Paraflex) vs. Placebo in Spastic Patients" by Dr. J. V. Basmajian, Emory University School of Medicine and Dr. Carl Strom, Georgia Retardation Center.
5. "A Study of Stereotyped Behavior in the Mentally Retarded" by Dr. Richard K. Davenport, Georgia Institute of Technology.

I hope this is the information you need. I should add that none of these are financed by Federal Grants to the Georgia Retardation Center.

Sincerely,

JAMES D. CLEMENTS, M.D., *Director*.

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MENTAL RETARDATION DEVELOPMENTAL TRAINING CENTER, INDIANA UNIVERSITY, BLOOMINGTON, IND.

LIST OF RESEARCH PROJECTS RESULTING FROM UAC PROGRAMS

Operational Studies of Foster Home Care

1. Central food distribution study.
2. Furniture depreciation study.
3. Laundry study.
4. Menu preparation study.

Preliminary Pilot Research: The Effects of Pre-Natal Malnutrition on Children's Performance

The impact of this research has relevance to many thousands of mildly retarded children existing in poverty environments throughout the world. Basic research conducted so far with animals appears to support the value of adequate nutrition, during the pre-natal and early post-natal life of an individual, which will raise their general level of intelligence.

In the future, additional efforts will be made to assess the effect of environmental enrichment as well as nutrition supplementation in offsetting intellectual deficits in infants associated with maternal malnutrition.

Dr. Samuel L. Guskin, Director of the Center for Educational Research and Development in Mental Retardation also has research projects taking place within our facility.

DR. MILTON V. WISLAND, *Director*.

MAILMAN CENTER FOR CHILD DEVELOPMENT, UNIVERSITY OF MIAMI, MIAMI, FLA.

Research projects

Training Parents of Severely Retarded Pre-School Children In Behavior Management Techniques. R. P. Toister, Sharon Pesek, Betty Bell, Ethyl Souлары.

The Modification Of Oral Reading Behavior In Dyslexic Children: an exploratory study, NSF, Institutional Grant to CDC. R. P. Toister, Lee Worley and Polly Peterson.

Functional Evaluation of Perseverative Behavior In Mentally Retarded Children. R. P. Toister, CDC and Sunland Training Center.

Biochemical And Behavioral Effects Of Magnesium Pemoline On A Child With Hyperauremia. Abbott Drug Co. Report Sent. R. P. Toister and William Nyhan.

Intelligence And Behavior In Persons With XYY Sex Chromosomes. (In progress). J. M. Berg, G. F. Smith and R. P. Toister.

Clinical research studies

1. De Lange Syndrome: clinical, behavioral and laboratory studies (Dr. C. Shear).

2. PKU Cooperative Study (Dr. Shear—Dr. Helmken).

3. Studies of Inborn Errors of Metabolism (Drs. Shear, Helmken, Condron).

4. Laurence—Moon Biedle Syndrome—Clinical and Genetic Studies (Dr. Helmken).

5. Infant Cry Studies and Language Development (Dr. Truby).

6. Screening for Metabolic Disorders (Dr. Tocci).

7. Evoked Potential Examination in Children with Brain Damage (T. Shipley, Ph. D. (Ophthalmology), C. Shear, M.D.).

Completed and on-going research projects

Grassi, J. R., Auditory Vigilance Learning of Brain Damaged, Behavior Disordered and Normal Children. Published 1970.

Grassi, J. R., Block Substitution Test for Measuring Brain Damage, (book), published 1970.

Grassi, J. R., Early Identification and Remediation of Developmental Deficits. In collaboration with Dade County Public Schools.

Grassi, J. R., Investigation of Minimal Cerebral Dysfunctioning.

Grassi, J. R., Identification of the Effects of Cognitive Deficits on Learning.

Grassi, J. R., Presentation of Learning Disabilities by Microscope Procedures.

Grassi, J. R., Detection and Remediation of Developmental Deficits in Mentally Retarded Children.

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FREDERICK RICHARDSON.

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UNIVERSITY OF CALIFORNIA, LOS ANGELES, DEPARTMENT OF PSYCHIATRY, SCHOOL OF MEDICINE, THE CENTER FOR THE HEALTH SCIENCES, LOS ANGELES, CALIF.

UCLA UAF RESEARCH PROJECTS

1. *Who Are the Patients Who Seek Our Services?*

Will our patients come with equal probability, from all social, ethnic, economic and educational strata of our society? The answers to this question should be applicable to the selection factors that make any university clinic desirable as well as available and accessible, either to certain segments of society only, or to all.

2. *What Factors Are Involved in the Referral Process?*

Do referring practitioners differentiate in their selection of those who are sent to the university clinic? Is there bias based on some type of social stratification? For example, do schools most often refer the disadvantaged child to a mental retardation clinic, and those children of more advantaged circumstances to a general psychiatric clinic? Since we will have both types of programs functioning side by side, we will examine this issue.

3. *What Needs Do Parents Conceptualize When They Come to a Clinic?*

Do they come seeking amelioration of a specific symptom or do they still seek diagnosis in spite of previous diagnostic workups? Is prognosis frequently a key question? Are the conceptualized needs related to symptoms and characteristics of the patient, or to social stratification?

4. *How is the Diagnosis Established?*

In a multi-disciplinary clinic, a variety of professionals collect information during the diagnostic process. These series of observations become part of a sizeable data pool. In all probability, some bits of information are more relevant than others to the establishment of a recorded diagnosis. Multi-disciplinary studies are expensive, and economy demands that irrelevant information be eliminated. The current clinical model is based on tradition. A re-examination of the diagnostic process is critical.

5. *Can a Systems Approach Assist Clinical Decision-Making?*

What type of information is required by clinicians for making sound clinical decisions? Can this information be identified, collected, stored, and retrieved on existing data processing equipment? Can it be made immediately available through terminals to the clinician?

6. *What is the Role of Music as a Therapeutic Device?*

Empirical observations attest to the fact that many retarded children enjoy music. Others do not. Can we establish an assessment situation which both differentiate and furthermore determine the intensity of gratification received from different kinds of music. Can this be put to therapeutic use for teaching purposes and the improvement of behavior?

7. *What is the Difference in the Rate of Chromosomal Abnormalities in Different Groups of Children?*

An investigation of the frequency of the chromosomal disorders is being conducted in the following three patient populations: the severely mentally retarded with major congenital malformations, the mildly retarded without malformations, and children with behavioral disorders.

8. *Can a Behavioral Assessment Scale be Developed that is Prognostically Relevant for the Performance of Retarded Pre-School Children?*

In an educational assessment laboratory students are assigned different tasks under varying circumstances. The response of the student and the teacher are recorded on a scale of twenty different behavioral variables. This data is being analyzed to determine its relevance to predicting future performance in an educational program and its relevance to education program planning.

9. *What is the Influence of Aversive Events on Human Behavior?*

Some research indicates that aversive events or punishment reduces self-destructive and maladaptive behavior in schizophrenic and retarded children. Can these findings be replicated? Is the kind of aversive event related to its success in eliminating the self-destructive behavior? Is there a difference when it is applied to a child diagnosed as schizophrenic rather than retarded?

10. *How Does One Determine Hearing Acuity in a Child Who Cannot Respond?*

The typical hearing test requires that the patient be able to indicate to the examiner what he hears and what he does not hear. The child who is unable to respond was presumed to be deaf. Techniques are being refined to determine the

child's hearing ability, even though he is unable to give verbal, motor, or other responses indicating his auditory capacity.

CHARLES V. KEERAN, JR.,
Administrative Associate, Mental Retardation Program.

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UNIVERSITY OF WASHINGTON, CHILD DEVELOPMENT AND MENTAL RETARDATION
 CENTER, CLINICAL TRAINING UNIT, SEATTLE, WASH.

The following are some of the research projects currently being carried on within the University Affiliated portion of our Child Development and Mental Retardation Center.

- Computerized Assessment of Diets for the Evaluation and Control of Weight Related Disorders (Nutrition).
- Development of Computer Based Information System for Data on all Children seen by the Center (R. Fallis).
- Teenage Social Behavior—a technique of determining normal social adolescent behavior (A. Kimball).
- Interdisciplinary Study of Obese Adolescent and Normal Weight Adolescents (S. L. Hammar, M.D., M. M. Campbell, Ph. D., other Adolescent Clinic personnel).
- Factor Analytic Study of the Children's Manifest Anxiety Scale (M. M. Campbell).
- Achievement and Non-Achievement Study of High School Juniors (M. M. Campbell).
- "Do We Reach the Retarded" A Comparison of Two King County Clinics" (M. Campbell).
- Comparison of the Population Served by a University Clinic for Retarded Children With the Population of the Community It Serves (M. Campbell, R. Justice, etc.).
- Evaluation of the General Service: Intermediate Screening Evaluation and Treatment Service for Children Suspected of Handicapping Conditions (R. Penn).
- An Assessment of Care Given Under the Auspices of M & I Program—"The Criteria of Risk" (W. Wenner).
- A Study of State in Young Infants (W. Wenner).
- Relationship of the Ability to Identify Objects and Events by Sound to Aspects of Reading Performance, Maturation, and Sensory Compensation (F. Lamson).
- Relationships Between Visual-Motor Performance, Academic Achievements, and Medical Findings in Children with Learning Disorders (F. Lamson with O. Ramsey).
- The Practical Reliability of the Denver Developmental Screening Test (F. Lamson with K. Barnard).
- A Study of the Value of Multidisciplinary Evaluation of Children (F. Lamson)—proposed.
- Survey of Attitudinal Change in Dental Hygiene Students Before and After Training Periods with Mentally Retarded Patients (R. Rolla—on-going 3 yrs.).
- Survey of Oral Health Needs and Oral Health Care Among A Group of Disadvantaged Youth (R. Rolla).
- Deviations of Development of Oral Structure in Handicapped Children (R. Rolla).
- National Collaborative Study of Children Treated for Phenylketonuria (V. Holm).
- Language in Children with Phenylketonuria (V. Holm, S. Andruess, D. Hedrick).
- 10 Year Follow-up on Children Seen in the Child Study Clinic (V. Holm, J. Grant).
- Comparative Study on Two Different Methods of Developmental Stimulation of Infants with Downs Syndrome (V. Holm, H. Robinson, G. Norris).
- "The Development of an Assessment Tool for Use with the School Aged Child" (B. Collar, M. B. Light, and G. Norris).

- "The Effects of Total Mobilization for the Child with Myelodysplasia" (M. Hill).
- "The Effectiveness of the Nurse as Therapist in a Behavior Modification Program in the Home" (M. Hill).
- A descriptive study of the range and frequency of problems handled by the nurse following selected families in a Well Child Clinic (C. King—proposed).
- A Study of the Quality and Quantity of Health Supervision Being Provided to Well Child Clinic Families and the Implications for the Pediatric Nurse Clinician's Role (C. King—proposed).
- "The Development of an Assessment Tool for Use with the School-aged Child" (M. B. Light, B. Collar and G. Norris).
- "Families of Children with Down's Syndrome: Life Situations and Adaptive Strategies" (G. Norris).
- "Relationship of Temporal Spacing to the Outcome of Pregnancies Following Abortions" (G. Norris).
- "A Study of Sucking Patterns of Prematures at Different Gestational Ages" (M. Powell).
- "A Study of Exaggerated Maternal Ambivalence and the Handicapped Child" (E. Worthly).
- Development of Language Forms Involved in Tag Questions Elicited from Children (Kunze and McGrath).
- Alternative Procedures for Classifying Early Childhood Utterances (Hedrick and Prather).
- "Live" vs. "Taped" Language Sample Comparisons (Hedrick and Prather).
- Stimuli and Intensity Factors in Hearing Assessment of Young Children (Thompson and Denman).
- Effects of Stimulus Duration and Inter-stimulus—interval on Rate of Habit of the Average Evoked Response (Weber and Denman).
- The Influence of Certain Psycholinguistics factors upon Young Children's Imitative Responses (J. Kemp).
- Effects of Two CNS stimulants on the Auditory Evoked Response in Children (Weber and Sulzbacher).
- Performance on visual concept identification Tasks as a function of Linguistic Representation (Helmick and Weber).
- Habituation in Normal and Mentally Retarded Children (Weber).
- Family Comparison Study, M. M. Campbell, Ph. D., Seattle King County MH-MR Board, 1/2/69-5/31/70.
- Language Acquisition in Young Children, L. H. Kunze, Ph. D., Axe-Houghton Foundation, 4/1/69-3/31/71.
- Interdisciplinary Study of Adolescent Obesity, S. L. Hammar, Washington State Heart Association, 5/1/69-12/31/70.
- Educational Services to Maternal and Infant Care Project Mothers, W. Wenner, MD United Cerebral Palsy Assn., 7/1/69-6/30/70.
- Effects of Otitis Media on Language Development—L. H. Kunze, NICHD (9/1/70-8/31/71) (Pending).
- The Sequential Process of Early Language Learning, D. Hedrick; E. Prather NICHD, 9/1/70-8/31/71 (Pending).
- Development of Training Procedures for Infants with Down's Syndrome Washington State Department of Institutions, H. Robinson, Ph. D. G. Norris, M. N., V. Holm, M. D., 7/1/70-9/30/72 (Pending).
- The Effects of Practice on the Development of Fine Motor Skills in Infants W. Wenner, M. D. and P. Pipes, Nutritionist.
- The following are from the Experimental Education Unit of the Child Development and Mental Retardation Center:
- Work Study Program, N. G. Haring and A. H. Hayden, OEO, 7/1/70-6/30/71.
- Investigation of Systematic Instructional Procedures to Facilitate Academic Retarded Disadvantaged Children, N. G. Haring, Office of Education, 6/1/69-5/31/71.
- A Planning Study for the Investigation of Procedures for Motivation of Socially and Culturally Disadvantaged Youth Toward Vocational Training and Job Performance, N. G. Haring, Office of Education, 5/1/69-4/30/70.
- Seriously Emotionally Disturbed Development Grant, G. Fargo, Office of Education 9/1/69-8/31/70.

A Program Project for the Investigation and Application of Procedures of Analysis and Modification of Behavior of Handicapped Children, N. G. Haring, Office of Education, 4/1/70-3/31/72.

Application for Training Grant for Summer Program in Minimal Brain Dysfunction, Alpha Gamma Delta, 6/1/69-8/31/69.

Oregon Traineeship, N. G. Haring, Oregon.

Instructional Materials Center Research, N. G. Haring, Public Instruction State of Washington.

Computer Assisted Instruction for Handicapped Children, R. Marum and A. H. Hayden, Public Instruction, State of Washington through Intermediate Dist. # 110.

Research Chair in Mental Retardation, A. H. Hayden, Washington Association for Retarded Children Fund, 12/1/70-11/30/71.

We hope this is the information you are in need of for Congressman Rogers. If we may be of further assistance, please let us know.

ROBERT W. DEISHER, M. D.,
Professor of Pediatrics,
Director, Clinical Training Unit, CDMRC.

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UNIVERSITY AFFILIATED CENTER FOR CHILD DEVELOPMENT AT GEORGETOWN

We have been having funding difficulties. We have *no* directly funded research activity to members of our core staff. There are some projects which are related and part of the program is a direct result of having our facility.

These projects are:

Title	Funding source	Description
1. Diagnostic Nursery School.....	Office of Education.....	As part of evaluation aspects of this demonstration project, 3 specific studies are underway involving instrument development and attitudinal assessments.
2. Training Materials for Day Care Services.	Office of Child Development.....	Project evaluation includes study of use of audio-visual materials in integrating handicapped children into normal settings.
3. Bladder Functioning in Myelomeningocele.	Social and Rehabilitation Services.	Center providing the ongoing multidisciplinary longitudinal assessments for the project directed by department of urology.
4. Delivery of Psycho educational Services.	HSMHA Maternal and Child Health.	Directed by Children's Hospital, Center is providing the third level of care in this system.
5. Research Training in Immunology.	NIH (NICHHD).....	Significant part of training program, including specific project opportunities, are provided by Center.
6. Use of Heparin in Respiratory Distress Syndrome.	NIH (NICHHD).....	Providing backup for longitudinal multidisciplinary assessment for study children up to age 2.

In addition to these projects, the following currently unfunded studies have been started:

1. Infant stimulation of handicapped children.
2. Dermatoglyphic analysis of retarded.
3. Retardation in relation to juvenile delinquency in Washington, D.C.

ROBERT J. CLAYTON, M.D., *Director.*

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UNIVERSITY OF TENNESSEE, CHILD DEVELOPMENT CENTER, MEMPHIS, TENNESSEE

The following is a list of research projects that have been completed at the Center or are now in progress. The list is not complete but gives a sample of the research activity at the Center.

1. Title: *The Effects of an Intensive Language Program on Language and Psychological Test Performance.* Principal Investigators: Dolores Henderson, M.A.; Joyce Lewis, M.A.; Sam B. Morgan, Ph. D.

2. Title: *Token Reinforcement in a Head Start Class.* Principal Investigator: Vaughn Stimbert, Ph. D.

3. Title: *Delayed Matching in Perceptually Handicapped School Children.* Principal Investigator: Vaughn Stimbert, Ph. D.

4. Title: *A Regression Formula for Stanford Binet and Vineland Scores on Retarded and Normal Children*. Principal Investigator: William Wilson, M.A.
5. Title: *Relationship Between Intellectual and Social Development in Mongoloid and Non-Mongoloid Retardates*. Principal Investigators: Sam B. Morgan, Ph.D.; Anne Welbourne, M.A.
6. Title: *Intellectual Status of Children with Sickie-Celled Disease*. Principal Investigator: Lois Gilbert, M.A.
7. Title: *A Description of the Client Population at a Mental Retardation Diagnostic Center—Child Development Center, Memphis, Tennessee*. Principal Investigator: Nancy Rubin, M.A.
8. Title: *A Follow-up of Parents' Evaluation of Services Rendered by the Child Development Center, Memphis, Tennessee*. Principal Investigator: Nellie Tate, M.A.; Frances Ward, M.A.
9. Title: *A Study of the Opinion of Parents of Retarded Children Evaluated at Child Development Center*. Principal Investigator: M. Boatwright, M.A.
10. Title: *Attendance at Memphis-Shelby County Council for Retarded Children by Parents Known to Child Development Center*. Principal Investigator: Betty Baughman, M.A.
11. Title: *The effects of Various Reinforcers on Learning at Different Levels of Retardation*. Principal Investigator: Joseph Tramontana, M.A.
12. Title: *Behavior Modification with an Autistic Child: A Training Film on Principles of Behavior Modification*. Principal Investigators: Vaughn E. Stimbert, Ph.D.; Joseph Tramontana, M.A.
13. Title: *The Effects on Child Behavior of Teaching of Behavior Modification Principles to Parents in Groups*. Principal Investigators: Margaret Haynes, M.A.; Sam B. Morgan, Ph.D.; Faye Russell, M.A.; Vaughn Stimbert, Ph.D.; Joseph Tramontana, M.A.
14. Title: *A Longitudinal Study of the Psychological Characteristics of Children with Inborn Errors of Metabolism*. Principal Investigators: Hazel Capps, M.A.; Cathy Lamb, M.A.; Sam B. Morgan, Ph.D.
15. Title: *The Relationship between Nutrition Problems and Socio-Economic Status, Intellectual Level, and Race*. Principal Investigators: Mary Ann Harvey, Ph.D.; Kitty Coffey, M.A.
16. Title: *Delineation of the Noonan Syndrome*. Principal Investigator: Robert Summitt, M.D., et al.
17. Title: *Chromosome Damage in Subacute Sclerosing Panencephalitis*. Principal Investigator: Robert Summitt, M.D., et al.
18. Title: *Development of Techniques for Prenatal Diagnosis of Chromosomal Abnormalities and Biochemical Inborn Errors*. Principal Investigators: Robert Summitt, M.D., et al.
19. Title: *Studies in Cockayne Syndrome*. Principal Investigator: Robert Summitt, M.D., et al.
20. Title: *Systematic Study to Identify Current Strengths in Day Care Center*. Principal Investigators: Faye Russell, M.A.; Margaret Haynes, M.A.
21. Title: *A Study of the Action Taken by Parents regarding Recommendations of the Child Development Center*. Principal Investigator: Mary Todd, M.A.
22. Title: *The Effects of Group Counseling in Helping Parents Adjust to and Implement CDC Evaluation and Recommendations*. Principal Investigator: Mary Beth Wingfield, M.A.
23. Title: *Biochemical Effects of Nerve Growth Factor on Neuroblastoma Cells in Culture*. Principal Investigator: Samuel Molinary, Ph.D., et al.
24. Title: *Cytogenetics in Mentally Defective Children with Anomalies: A Controlled Study*. Principal Investigator: Robert Summitt, M.D.
25. Title: *Behavioral and Intellectual Characteristics of Children with Minimal Cerebral Dysfunction*. Principal Investigator: Sam B. Morgan, Ph.D.

RESEARCH NEEDS AND PROPOSED RESEARCH AT THE CHILD DEVELOPMENT CENTER,
UNIVERSITY OF TENNESSEE

Although the primary function of the Child Development Center is training, there is continuing interest among staff members in research in the area of child development. In fact, in many disciplines represented at the Center, research is considered to be a very vital aspect of the training of students. It is felt that all students would benefit from exposure to an active, ongoing research program. Many students, especially at advanced levels of training, could actually participate as investigators in research projects. Through such participation they could become familiar with special research problems in the

area of child development and learn research designs and techniques particularly applicable to the area. Further, the student would have the opportunity to participate as a member of an interdisciplinary research team. In short, it is felt that an active, productive research program, in which staff members and students are trying to contribute to the expansion of knowledge in child development, would add to the enthusiasm and vitality of our over-all program and would especially enhance our training program.

This report will deal with research needs and current and projected research at the Center. No attempt will be made to present detailed research descriptions or proposals but rather to present an overview in the form of brief summaries that reveal the need for funds for personnel, equipment, computer analysis, etc.

Research needs

A. Coordinator of Research.—In order to develop and maintain an effective interdisciplinary research program, a full-time research coordinator is urgently needed. Such a person would be responsible for stimulation, consultation, and coordination of all disciplines in research. He would serve as chairman of the Research Committee and serve as consultant to all staff members concerning research ideas and design. One very critical function would be to coordinate interdisciplinary research within the Center and to coordinate research functions with training and service functions. He would also be responsible for coordination of cooperative research projects with other agencies.

The Research Coordinator could fill a very significant need in the area of program evaluation and record-keeping. He could develop methods of collecting data relevant to program evaluation and planning and could oversee collection of data for statistical reports.

The Research Coordinator would serve a significant function in keeping the Center informed of possible sources of research funds and in aiding in the acquisition of such funds.

B. Equipment needs.—The following equipment would be needed in many of the research projects proposed in the following section. This list of equipment is not complete or detailed but presents some of the more expensive types of equipment that figure prominently in our research planning.

1. Audio-visual equipment (e.g., video tape equipment, etc.).
2. Biochemical equipment (e.g., amino acid analyzer).
3. EEG equipment.
4. Human console and associated recording and programing equipment (for research on perceptual and other learning handicaps).

Clinical assessment will include (1) measurement of height-weight, (2) skin-fold measurement, (3) clinical signs (hair, face, lips, tongue, gums, teeth, glands, and skin).

Dietary assessment: (1) Dietary histories—detailed, (2) three-day food intake records calculated.

In order to conduct this research additional personnel (1 pediatrician, 2 nutritionists, 2 laboratory technicians) will be needed in addition to the equipment needs. Funds would also be needed for computer analysis of data.

Title: A Longitudinal Study of the Nutritional Status of Retarded Children and Non-Retarded Children

Principal Investigator: Mary Ann Harvey, Ph.D.

Summary: Every child evaluated at the Child Development Center will be screened by a nutritionist or dietitian. If any nutritional problems are detected, the child will be given a complete nutrition evaluation including clinical, biochemical, and dietary assessment of nutrition status.

In order to assess the nutrition status adequately, biochemical equipment will be necessary. This includes hematology equipment, thin-layer and gas chromatographic equipment, blood-gas analyzer, electrophoresis apparatus, amino acid analyzer, spectrophotometer, centrifuge, etc.

Biochemical testing will include:

1. Assessment of calorie status (BMR and blood glucose).
2. Protein status (blood amino acid concentrations) (Creatinine excretion/m. ht.) (urinary sulfate/creatinine ratio) (urinary excretion of hydroxy-protein—This has not been thoroughly tested in population studies and could be a study all in itself).
3. Iron (CBC) (serum iron levels and serum iron binding capacity).
4. Vitamin A (serum carotene and vitamin A levels).

5. Ascorbic Acid (serum or plasma ascorbic acid) (white blood cell-blood platelet ascorbic acid conc.).
6. Calcium (Bone age).
7. B complex (urinary excretions).

Title: A Long-Range Study of Psychological Characteristics of Children with PKU and other Metabolic Disorders

Principal Investigator: Hazel Capps, M.A.

Summary: Psychological data is being collected systematically on all phenylketonuria patients and will be collected on all other patients with inborn errors of metabolism as these become identifiable. The frequency of evaluation and the psychological instruments to be used have been pre-planned so that long-range studies of psychological characteristics can be conducted for each type of disorder and comparison studies be done utilizing data from the different disorders.

Much of the above planned research is dependent upon better detection of the specific metabolic disorder and would, of course, require adequate biochemical equipment.

Title: The Development of Instrumented Assessment Devices for Detecting and Remediating Perceptual and Learning Handicaps in Children

Principal Investigator: Vaughn E. Stimbert, Ph. D.

Summary: The purpose of this research will be to develop diagnostic and remedial materials appropriate to automated presentations. It will be aimed at the early identification and treatment of specific learning disabilities in pre-school and primary grades. A unique feature will be the analysis of time relationships in stimulus presentations and in subjects' responding in order to determine if these subtle behavioral dimensions can contribute to the early identification of problem behaviors.

A basic premise is the feeling that there are at least four major deficiencies in traditional assessment devices which can be at least partially corrected by an automated or instrumented approach. First, a child's tendency to respond differently to different examiners is a major source of error in testing and leads to difficulties in comparing scores obtained by children tested by different examiners. The confounding of social variables with intellectual variables would be minimized in a setting which limits the subject's contact with the examiner. Second, many subtle time relationships between stimulus and response are not available for analysis in the typical test situation and may be diagnostically significant. With little expense, timers and print-out counters can continuously monitor and record extensive data on response latencies. Third, most assessment devices do not offer a remedial capability for diagnosed deficiencies. With appropriately designed materials it would appear to be feasible to use diagnostic materials as the curriculum for remediation. Current work in programmed instruction, particularly that in computer assisted instruction, strongly indicates that testing and teaching (or diagnosis and remediation) are most effective when combined into one program such that performance on previous tasks determines the level of difficulty and nature of materials on immediately following tasks. Immediate knowledge of results or reinforcement also appears to be an important feature of programming. Because of the continuous monitoring necessitated by such an approach, automation is required in presenting materials, recording responses, and in the differential reinforcement of these responses. Fourth, because of the manpower shortage in all phases of psychological assessment and remediation, any technique which frees highly trained personnel from routine tasks should extend their capabilities to the more important consultative and planning roles.

Both matching-to-sample and oddity learning paradigms will be used. The following is a minimal estimate of expenses for such research:

	<i>Amount</i>
Human console and associated recording and programming equipment-----	\$7, 000
Development of materials including the production of 35-mm slides and sound tapes-----	2, 000
Secretarial, statistical analysis and miscellaneous expenses-----	1, 000
Total -----	10, 000

Title: Observational Learning of Programmed and Filmed Materials

Principal Investigator: Vaughn E. Stimbert, Ph.D.

Summary: In spite of general agreement that imitation is a highly efficient way to acquire complex responses, very few laboratory studies of this phenomenon

have been accomplished. This research will study observational or imitational learning in two settings. First, existing computer assisted instruction programs and equipment will be used to determine how much a student can learn from observing the performance of another at a computer terminal and what combination of practice and observation might be optimal. Second, films or video tapes of appropriate and adaptive classroom behaviors will be made and tested to determine their effects on classes characterized by inappropriate, maladaptive (disruptive) behavior.

A basic goal of the above research will be to determine if expensive modes of instruction such as CIA designed for individual subjects can be most efficiently used by allowing group observation of learning prior to, if not in lieu of, actual practice.

Since the Memphis Board of Education has Computer Assisted Instruction terminals and programs available and the Child Development Center has some photographic equipment already available, this research will require minimal support funds.

	<i>Amount</i>
Video tape equipment and/or films and film processing-----	\$2,500
Secretarial, statistical analysis, publishing and miscellaneous expenses----	2,500
Total-----	5,000

Title: A Comparative Study of Feeding Skills Development and Mental Age

Principal Investigators: Mary Ann Harvey, Ph.D.; Joy Crawford, B.S.

Summary: The Vineland Social Maturity Scale gives the mental age at which children normally acquire certain feeding skills. Little or no information is available on how or when feeding skills develop either in the retarded or non-retarded child population.

This study will have the following objectives:

1. Determine feeding skill abilities of three-four year old children with average or above intelligence.
2. Determine feeding skill abilities of children with a M.A. of 3-4 years old, but who are moderately retarded (chronological ages of 6-8).
3. Comparison of the feeding skill abilities of the two groups to determine whether or not any differences exist in the order of acquisition of feeding skills in retarded and non-retarded children.

Video tapes could be used in recording, rating, and comparing feeding behaviors.

Title: Assessment of Behavior Modification Programs Through Video Tape

Principal Investigators: Sam B. Morgan, Ph.D.; Vaughn E. Stimbert, Ph.D.

Summary: Video tapes will be made of subjects' behavior at various stages of behavior modification. Baselines of specified problem behavior will first be recorded on tape and then at intervals further tapes will be made to assess effectiveness of behavior modification in these problem behaviors. The systematic video taping will not only provide an objective record of the child's progress for research purposes but will also provide valuable training material.

Title: Systematic Study to Identify Current Strengths in Day Care Center

Principal Investigators: Faye Russell, M.A.; Margaret Haynes, M.A.

Summary: This study is designed to identify some of the current strengths in the Day Care Center as they now exist. In addition, selected parents will be chosen for the purpose of identifying some attitudes which prevail among parents of children currently attending UCP. The study, hopefully, will develop and evaluate plans for preserving particular identified strengths in the New Center and will move into a Second Stage of the project, whereby documentation can be further carried on in the new setting with a more sophisticated group as well as additional adjuncts (e.g., videotape).

Title: Collaborative Study with Children and Youth Project on Factors Relating to Malnutrition in Low Income Neighborhoods

Principal Investigators: Eileen Conway, Ph.D.; Mary Ann Harvey, Ph.D.; David James, M.D.; Sam B. Morgan, Ph.D.

Summary: This project would survey four low-income census tracts in an attempt to answer the following questions:

- (1) What is the incidence of malnutrition?
- (2) What are the specific types of nutritional problems?

- (3) What is the relationship between malnutrition and the following factors?
- (a) Family income.
 - (b) Food-buying habits and management of funds.
 - (c) Use of available community resources.

Biochemical studies of nutritional status would be conducted as well as a survey of the nutritional and food-buying habits of the population.

Funds would be needed for (1) biochemical tests and equipment, (2) payment of personnel to collect survey data, and (3) computer analysis of data.

Title: Collaborative Project With Arlington State School on Evaluation of Low Level Retardates

Principal Investigators: Robert Cassess, Ph.D.; Sam B. Morgan, Ph.D.

Summary: A substantial problem in the field of mental retardation is the behavioral evaluation of ambulatory low level retardates. Existing intelligence tests in many respects do not apply to these people. Moreover, there is considerable question as to how relevant an IQ figure is for such people. This question is both theoretical and practical. It is not known whether an IQ of 10 is twice as much as an IQ of 5 or, for instance, how much more is IQ 16 than IQ 8. Practically speaking, the real evaluation concern with people is what kinds of purposeful behavior do they habitually engage in. That is, what do they do to help themselves in the daily task of living. Ultimately, the problem of predicting training potential must be faced, i.e., given what this particular retardate can do at a certain level, can he be trained to do more and in what areas.

There are relatively few procedures available on which to rate the daily functioning of the very low level mental retardate. Perhaps the best known is the Vineland Social Maturity Scale (Doll 1947). Lesser known are the Pinecrest Behavior Meters (Cassel, Cassel, & Milford 1967) designed specifically for retardates. Both of these procedures rely upon an informant, i.e., the word of somebody who presumably knows the retardate. The Central Wisconsin Colony Scales of Adaptive Behavior (Balthazar, Roseen, & English, 1968) also generally deal with the same kind of behavior except in this case, a trained observer supplies the data.

Just how accurate a reporter is the ordinary aide or attendant and how much more accurate is a trained observer? The thing which needs to be investigated, and this is basic to the evaluation of training of low level retardates, is *the relative validity of various methods of identifying this behavior.*

In essence what I am suggesting is that financial aid be sought to set up situations of various kinds of observation of retardates and then get a quantitative estimate of how accurate they be. What is necessary is to compare the reports of aides with the reports of observers and with what judges claim appeared on video tapes of behavior. Without this kind of basic research, I submit that we may well be wasting a lot of time and effort as we try to treat with and teach the profoundly retarded.

Money would be required to hire observers, to rent video tape and equipment, to hire judges of the tapes, and to hire a few psychologists (and consultants) to operate the project. The value of the project would not only be in obtaining the general information that is needed, but probably a set of scales could be developed and, probably some data as to which kinds of present behavior or which kinds of present behavior pictures (constellations) enable predictions of trainability.

ROBERT G. JORDAN, M.D.,

Director, Professor of Child Development and Pediatrics.

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CENTER FOR DEVELOPMENTAL AND LEARNING DISORDERS, UNIVERSITY
OF ALABAMA, BIRMINGHAM, ALA.

INTERDISCIPLINARY FUNDED RESEARCH PROGRAMS

1. *A comprehensive Early Educational Program for the Handicapped*, Presently funded by the U.S. Office of Education, \$25,000 annually, Kay King, Ed.D.
2. *Development of a Special Education Program in a University Affiliated Facility*, Presently funded by the U.S. Office of Education, \$30,000 annually, Charles E. Herron, Ed.D.
3. *Clinical Aspects of Inherited Disorders*, U.S. Maternal and Child Health, presently funded at \$39,312 annually, Wayne Finley, M.D., Sara Finley, M.D.

4. *Cytogenetic Studies in Mental Retardation and Birth Defects*, presently funded by U.S. Maternal and Child Health, \$42,732 annually, Wayne Finley, M.D., Sara Finley, M.D.
5. *Nature and Mechanisms of Chronic Congenital Infection in Man*, presently funded by NIH, \$32,194 annually, Charles Alford, M.D.
6. *Birth Defects Center Research*, presently funded by the National Foundation, \$32,704 annually, Charles Alford, M.D.
7. *Mental Retardation Staff Development Program*, originally funded through U.S. Public Health Service, annually \$86,000, G. J. Bensberg, Ph.D.
8. *A Proposal to Establish a Training Program for Administrators and Program Directors of Mental Retardation Facilities*, conditional funding approval received from U.S. Social and Rehabilitation Service, Rehabilitation Services Administration, first year period, \$71,700, G. J. Bensberg, Ph.D.
9. *Study of Immunoglobulin E and Its Interaction with Connective Tissue*, \$2,000 annually, University of Alabama, Daisy S. Lee, M.D.

INTERDISCIPLINARY RESEARCH PROGRAMS NOT YET FUNDED

1. *Programmed Speech Discrimination with Educable Mentally Retarded Children*, recently submitted to NICHD requesting \$78,786, Robert Cantrell, Ph.D.
2. *Automation of Ultramicro Analysis of Macromolecules*, recently submitted to NIH for funding, first year funding requested amounting to \$438,573. Seymour S. West, Ph.D., Andrew E. Lorincz, M.D.
3. *Short Term Training Project with Dentists Working with the Handicapped*, G. J. Bensberg, Ph.D., Community Health Service, \$6,284.

INTERDISCIPLINARY, FORMAL ON-GOING APPLIED CLINICAL RESEARCH STUDIES NOT FUNDED BY OUTSIDE RESOURCES

1. *Auditory Threshold Variations During Periods of Induced High and Low Heart Rate*, A. J. Dahle, Ph.D., Sam Saxon, Ph.D.
2. *Perceptual Motor Performance of Cerebral Palsied Children*, Sam Saxon, Ph.D.
3. *Pilot Project, St. Jude Hospital, Identification and Utilization of Local Resource Individuals in the Training and Education of Mentally Retarded Children Through the Utilization of Behavioral Modification Techniques, State Wide*, Richard Allison, Ph.D., Sam Saxon, Ph.D., Robert Cantrell, Ph.D.
4. *Ashton-Warner Reading Readiness Approach for Exceptional Children*, Kay King, Ed.D.
5. *An Exploratory Study of Chewing Difficulties with Mentally Retarded Children*, Nancy Patterson, M.S.
6. *A Demonstration Day Care Center With Severely Retarded Children with Parent Involvement*, Nancy Patterson, M.S.
7. *Group Therapy with the Mentally Retarded, Supervised by Social Services and Vocational Rehabilitation*, Dale Brantley, MSSW, J. Merrill Taylor, M.A.
8. *Development of Evaluation and Screening Devices for the Mentally Retarded*, Jerry Gist, B.S., Aspects of Vocational Rehabilitation.
9. *Utilizing a Medical Center Complex in the Development of on the Job Training and Work Experiences in the Areas of Housekeeping and Janitorial Services*, J. Merrill Taylor, M.A., Jerry Gist, B.S.
10. *Language Acquisition with Emotionally Disturbed Children*, David Daly, Ed.D Robert Cantrell, Ph.D.
11. *Dimensions of Oral Architecture in Down's Syndrome and Its Relationship to Speech*, David Daly, Ed.D., Joseph Sim, D.M.D.
12. *Personality Factors in Mentally Retarded Children in a Special Education School Setting*, Robert Cantrell, Ph.D., Mary Cantrell, M. S., Joseph Sim, D.M.D.
13. *Dietary Intake of Low Income Pre-School Children Enrolled in the Jefferson County Parent Child Center*, Harriet Cloud, M.S.
14. *Height, Weights, Skinfold Measurements and Dietary Intake of Mongoloid Children Enrolled in the Opportunity Center, Birmingham, Alabama*, Harriet Cloud, M.S.

15. *Effects of Positive Verbal Reinforcement on the Auditory Discrimination Performance of Educable Mentally Retarded Children*, A. J. Dahle, Ph.D., David Daly, Ed.D.
16. *Comparison of Pure Tone and Speech Reception Procedures for Screening Hearing of Trainable Mentally Retarded Children*, A. J. Dahle, Ph.D., Jean Covington, M.S.

CHARLES L. DAVIS, *Administrator*.

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NEW YORK MEDICAL COLLEGE, MENTAL RETARDATION CENTER, NEW YORK, N.Y.

RESEARCH PROJECTS

Psychology

- Longitudinal Study of I.Q. Stability in Mongoloids.
- Relationship of Bender—Gestalt to Achievement in Mental Retardation.
- Need Achievement of Parents and Child (doctoral dissertation).
- A Paraprofessional Training Program for Psychological Technicians (a demonstration project).
- A Psycho-educational Laboratory for Learning Disabilities with Mental Retardation (a research demonstration project).

Social Work

- Extending Clinical Services into the Community—a demonstration project.
- Evaluating Effectiveness of Group Therapy with Retarded Adolescents.
- Evaluating Impact of Counseling Parents of Mongoloid Children—Seven Years After Crisis Contact.

Neurology Division and Pediatrics

- Electroencephalographic Correlatives, If Any, versus Preceptual-Visuo Motor Dysfunction in Mentally Retarded Children.
- The Oculography Test—Its Value in Evaluating Minimal Brain Dysfunction—Paper presented at the AAMD Meeting in Washington, D.C.

Nursing

- Clinic Nursing Study—Failure to Thrive in a Severely Retarded Child.

Speech Pathology and Audiology

- An Investigation into the Incidence of Stuttering among the Community-Living Mentally Retarded.
- Selecting Techniques of Pediatric Aural Habilitation for Language Stimulation of Community-Living, Non-Hearing Impaired Retardates.

RESEARCH PROJECTS: NEUROPSYCHOLOGICAL LAB

- Investigation of Visual and Auditory Cortical Evoked Responses in Mentally Retarded and Normal Children.
- 2. Analysis of Interhemispheric Differences in Cortical Response to Visual Stimulation in Mentally Retarded and Normal Children as a Function of Rate of Stimulation.
- 3. Operant Conditioning Training of Eye-movement, Handwriting, and Walking in Cerebral Palsy, Congenital Nystagmus and Brain Injury.
- 4. Diagnosis of Deafness and Brain Damage in Neonates Utilizing Evoked Heart Rate Change and Evoked Cortical Responses.

MARGARET J. GIANNINI, M.D., F.A.A.P.,

Professor of Pediatrics,

Director, University Affiliated Mental Retardation Center.

Mr. ROGERS. Dr. Boggs, could you let us have your comments about reaching the poverty group for the record? I wanted some comment on what had been said about reaching the poverty group.

Mrs. BOGGS. Yes, sir, I will be very glad to.

(The following information was received for the record:)

MENTAL RETARDATION IN POVERTY AREAS A PROBLEM IN IDENTIFYING TRUE PRIORITIES

There is a persistent statistical relationship between reported mental retardation and the indices of poverty as localized in census tracts. The nature of this relationship is known to be complex.

It is recognized, for example, that mental retardation impairs earning potential, and thus may be said to be one of the causes of poverty. In fact, severe disability of which mental retardation is a primary component accounts for at least 15 percent of those who receive public assistance in the adult disabled category.

Many of the circumstances which attend poverty are also known to enhance the risk of mental retardation in children—poor nutrition in pre-natal as well as post-natal life, inadequate pre-natal care, greater exposure to certain infectious diseases, risk of lead encephalitis as a result of a child's eating peeling paint in old and deteriorating buildings, unfavorable sleeping conditions, lack of individual personal attention from a mother who has just too much to do because she works and has no household conveniences—any of these may depress a child's apparent level of intellectual functioning, either temporarily or permanently.

On the other hand there are some causes of severe mental retardation that are more often found in middle class families. Survival of children damaged at birth may be more likely in the family which has access to better care for their child. There are also ethnic factors; mongolism, phenylketonuria and Tay-Sachs disease are less common among blacks, for example.

The data which suggest a concentration of mentally retarded persons in disadvantaged neighborhoods need careful analysis before this simple statistic is used as basis for social action.

The data rely most heavily on school records, and when analyzed by degree of mental retardation, indicate that the geographical differences in apparent prevalence are most pronounced for the mildly retarded (those classed in schools as "educable") and much less significant for the severely and profoundly retarded. This is true even though, as indicated above, still more detailed analysis by medical classification may show differences in both directions.

Further consideration has to be given to the meaning of the reports from the Schools. In its recent publication *The Six-Hour Retarded Child*, the President's Committee on Mental Retardation speaks of the child who is "retarded 9 to 3, five days a week solely on the basis of an I.Q. score, without regard to his adaptive behavior, which may be exceptionally adaptive to the situation and community in which he lives." Such a child does not meet the generally accepted definition of mental retardation, but it appears that quite a number of such children from low income neighborhoods have been reported as retarded, and these reports have skewed the statistics. As former Commissioner James E. Allen, Jr., has stated "We know that many children living in ghetto neighborhoods would score low on intelligence tests, but we doubt that all such scores reflect retarded intellectual ability." Recently, Secretary Finch issued a caution to school districts having significant numbers of pupils for whom English is a second language, advising the schools not to classify Spanish speaking children as retarded merely on the basis of a verbal score on a psychological test given in English.

These and similar questions being raised by responsible public officials and educators are reinforced by the concerns of the representatives of the minorities whose poor members are most frequently classified by the schools as retarded. Most thinking observers agreed that, among those who appear to be functioning at a retarded level in school, there are some children who do have a continuing intellectual and social handicap, and some who are better described as socially competent but underachieving in the academic milieu, for any one of a variety of reasons. We do the latter no favor by labeling them as "retarded" and providing a separate system of services.

We do the truly retarded child in the ghetto no service by masking his problem under euphemisms about "cultural disadvantage." We do both society and the retarded child in the middle class neighborhood which lacks a program for him

no service by saying that statistically he isn't as important as the same kind of child in the ghetto. If neither has access to service, both are being cheated by society.

Neither is benefited, moreover, by a philosophy which suggests that "community facilities" should service only children from the same economic backgrounds. Generally speaking, the catchment areas of specialized facilities for the retarded are necessarily considerably larger than those of "neighborhood" schools or clinics. The precise location of a facility does not tell the whole story of its clientele. Many of the facilities built under PL 88-164 provide outstanding examples of economic and ethnic heterogeneity.

The problems of those who are more seriously retarded are found in every strata of society; they need a variety of specialized services; these needs are still to a large extent unmet even for the families which would otherwise be comfortably well off. Priorities should target the necessary specialized services into every area where there are unserved children and adults, using the kind of technical assistance and financial support most appropriate to the community to be served.

The problems of the mildly retarded which are statistically associated with the poverty areas need a different kind of attention, the most important components of which are: 1) action to alleviate these concomitants of poverty which cause or aggravate mental retardation or performance which appears to indicate mental retardation; 2) intensification of generic health services, social services, and education services, with special emphasis on the development of social and economic competence, in census tracts from which are reported high levels of prevalence of mild mental retardation (possibly spurious) among school age children. Such services should be directed to the dual purpose of improving the functioning of both the retarded and non-retarded under-achievers while maintaining them in the main stream of life as is appropriate to their minimal deviance.

In brief: Action to prevent mental retardation due to poverty-related factors must, of necessity be mediated through programs other than "mental retardation" programs. Action to improve the opportunities of children who perform in a retarded manner in school can be mediated most effectively by bringing greater expertise relative to this phenomenon into the social institutions which serve these children. This is one of the modalities which can be enhanced under new language in the proposed legislation which includes the term "specialized adaptations of generic services." It should be noted, however, that a still more effective effort could be mounted if agencies with special responsibility in the poverty area (welfare, economic opportunity, model cities etc.) were required to be more responsive to the fact that a significant segment of their target population is being reported as having this kind of functional handicap. Action to bring specialized services to the seriously retarded in poor communities will require not only special legislation and special programs but also recognition of the unique problems which inhibit development of this kind of resource. Of these, unrealistic matching requirements and reliance on purely local initiative to organize a project application are but two.

Mr. ROGERS. Thank you.

Mr. KYROS. I only have one question, Mr. Chairman. On page 4 of your statement, you say that—

In contrast, H.R. 15160 also refers to the training needs for persons dealing with the mentally retarded, but its language permits this to be interpreted and administered in a way that could lead to a great deal of vacillation.

Now, I think that training of people in this field is so vital. What is it in H.R. 15160 that is so deficient?

Dr. GIBSON. As the administration witness said in his testimony, there is no indication but the administration of new concern on their part to continue the support and development of university affiliated centers as a key area for training individuals. This then puts the

training into institutional settings, into community settings, many of which are poor. If this is associated with a great deal of service, we feel that the university affiliated centers have an opportunity to provide a background of experience for these people in a shorter period of time, to be more effective in the development of community services.

Mr. KYROS. Well, we have a community mental health center now in Portland, Maine. And I guess it is the only one in my State. Where would the training be done at a university?

Dr. GIBSON. The university affiliated center coming into that State would probably be established in a larger population area, relating to a medical school, and would incorporate several of your university departments, the education program, the nursing program, various other kinds of professional persons who would work with this problem.

Mr. KYROS. Thank you. Thank you very much, Mr. Chairman.

Mr. ROGERS. Mr. Nelsen?

Mr. NELSEN. I was interested in your statement about there being nothing in the testimony of the administration indicating support of the present bill. Do you have any information that would lead you to believe that they do not support it?

Dr. GIBSON. I listened to the comments this morning, sir, and I would think we would have to ask the chairman what his interpretation was.

Mr. ROGERS. I think there is no request for moneys in construction.

Mr. NELSEN. I know, but I am interested in what kind of a background is the basis for the statement that we are not interested.

Dr. GIBSON. I think we might extend this to Mr. Black's comment on the role of the Secretary's Committee on Mental Retardation. Again, I would have some concern on the language, and I think the secretary's committee has done much more, carried on a much more effective role on behalf of both the community needs and the university's needs than was indicated in the testimony this morning.

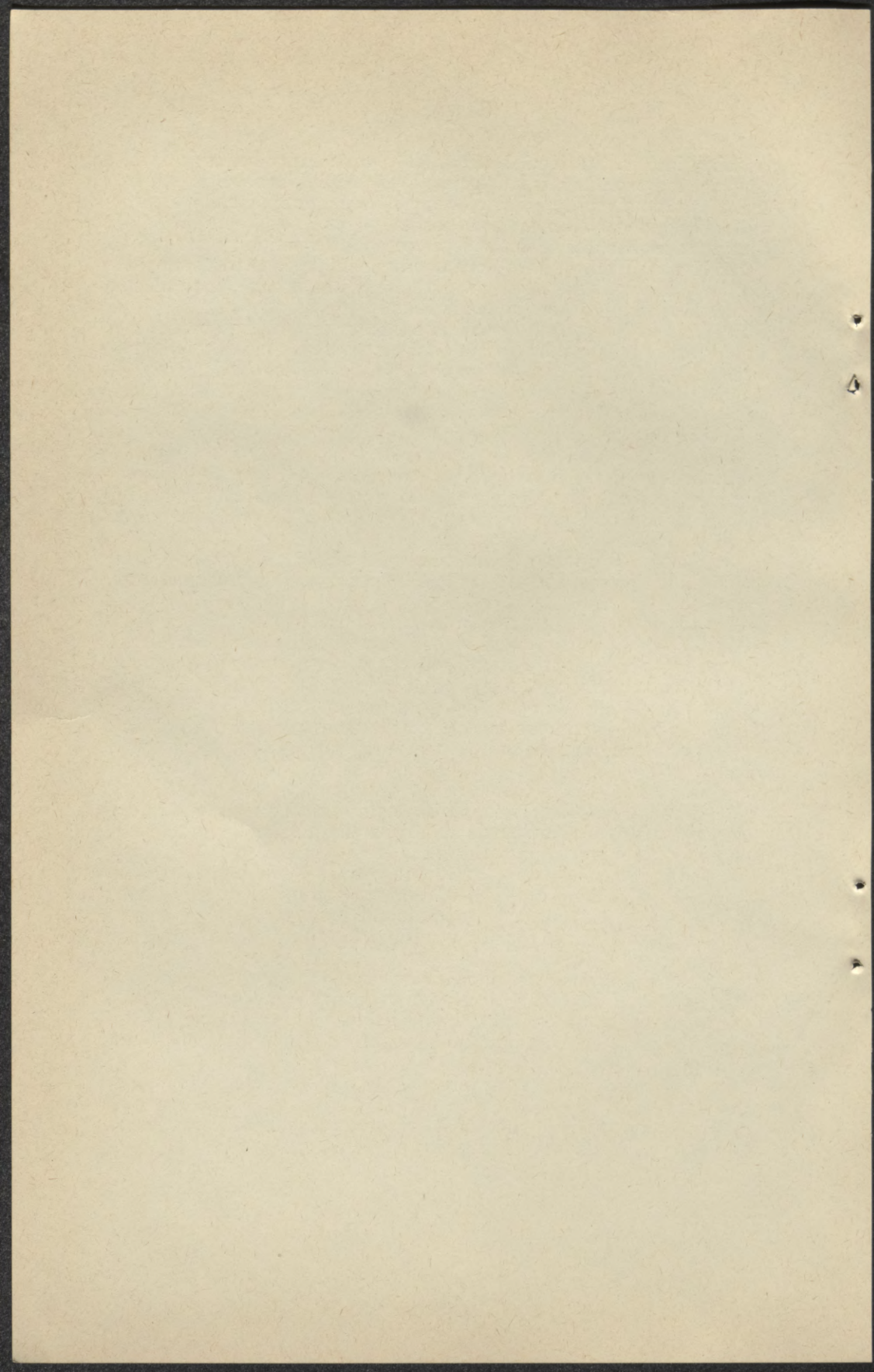
Mr. NELSEN. I am interested in the program, but I am also interested to be very sure that at no time do we leave an impression by an observation unless we are sure that we have the facts on which to base it. Now, it is usually better in the final result to keep to a minimum any conflagration that could be picked up and used politically. This is my concern, so I thank you for your testimony.

Dr. GIBSON. I thank you for bringing this to my attention. I am not very good in legalistic prose, and I might say that I wanted you to know that there was no malicious intent.

Mr. ROGERS. Dr. Gibson, thank you very much for being here and your testimony was most helpful, and if you will let us have for the record the additional information asked for as soon as possible, we will appreciate it.

The committee will stand adjourned until 10 o'clock tomorrow morning.

(Whereupon, at 12:30 p.m. the hearing was adjourned to reconvene at 10 a.m. on Wednesday, June 10, 1970.)



DEVELOPMENTAL DISABILITIES SERVICES AND FACILITIES CONSTRUCTION ACT OF 1970

WEDNESDAY, JUNE 10, 1970

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON PUBLIC HEALTH AND WELFARE,
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10 a.m., in room 2322, Rayburn House Office Building, Hon. John Jarman (chairman) presiding.

Mr. JARMAN. The subcommittee will please be in order.

Today we continue the hearing on bills to amend the Mental Retardation Facilities Construction Act to extend and improve the provisions therefore and for other purposes.

Our first witness this morning is Hon. Sherman P. Lloyd, our colleague from the State of Utah. Mr. Lloyd has a brief statement he would like to present to the subcommittee. Proceed as you see fit, sir.

STATEMENT OF HON. SHERMAN P. LLOYD, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF UTAH

Mr. LLOYD. I have always had a special interest in improving the facilities and programs for the care and education of our mentally retarded citizens. While a member of Utah State Senate I was the author of special legislation in this field.

Now, I am particularly concerned that the committee take favorable action on the legislation now pending that would extend and enlarge the Federal grant programs authorized by the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963.

The 1969 report of the President's Committee on Mental Retardation states that about 75 percent of the Nation's 6 million mentally retarded citizens could become self-supporting if given the proper kind of training at an early enough age. According to the report, an additional 10 to 15 percent could become partially self-supporting.

Yet the President's Committee says that about 5 million mentally retarded individuals are not being reached by any kind of service developed specifically to meet their needs. We have failed to help these people to become useful members of our society, and in failing them we have failed ourselves.

The Committee's report states that part of the blame lies with many of our public school systems. Few school systems have adequate training programs for the severely mentally retarded. In most school dis-

tricts tens of thousands of retarded children, too mildly affected to be assigned to traditional classes for the educable or trainable retarded, stumble through regular classes and drop out of school as soon as they can. Too often they wind up in the marginal-subsistence category, permanently dependent on State and Federal Government for welfare payments and health services.

The President's Committee estimates 60 percent of the 1,254,500 mentally retarded children in this country are not receiving education services. Many of the children who are receiving education services are plodding through courses of study that bear no relation to their needs and their abilities. If we fail to give our retarded citizens the proper education and training they need to become independent, we are dooming them to a life of welfare dependency.

The schools alone do not have the facilities to train the mentally retarded. In 1963 the Federal Government recognized the need for additional programs for the mentally retarded when it enacted legislation authorizing grants for the construction of mental retardation facilities. In 1967 Congress amended this legislation to provide funds for staffing the mental retardation centers with trained, professional personnel.

Utah has taken full advantage of this Federal program. The Holladay Children's Center in Salt Lake City and the Utah Valley Care and Training Center in Provo provide excellent training programs for mentally retarded children. Under present law Utah will receive about \$143,000 in construction and staffing grants for these and other training centers in fiscal 1970.

It is vitally important that we continue this program of grants for construction of facilities and provision of qualified personnel to conduct training programs. It is even more important that these services be expanded to permit earlier diagnosis of a disability, with more extensive training, care, and counseling. We must consider the possibility of expanding these services to cover those afflicted with cerebral palsy, epilepsy and related neurological disorders which constitute developmental disabilities.

I support the extension and expansion of the Mental Retardation Facilities Construction Act. This Congress must act to make sure that our mentally retarded citizens get the education and the training they need. The richest Nation in the world cannot afford to relegate its mentally retarded children and adults to the human scrap pile.

Mr. JARMAN. Thank you, Mr. Lloyd, for sharing your thoughts with us this morning.

Mr. LLOYD. It has been my pleasure, Mr. Chairman.

Mr. JARMAN. Our next witness this morning is Mr. John Baird, national field representative, United Cerebral Palsy Associations, Inc., Miami, Fla.

Mr. ROGERS. May I say, Mr. Chairman, I am delighted to see Mr. John Baird here. I know the fine work that he is doing, and of course the organization is doing. And we appreciate his presence here today.

STATEMENT OF JOHN BAIRD, NATIONAL FIELD REPRESENTATIVE,
UNITED CEREBRAL PALSY ASSOCIATIONS, INC.; ACCOMPANIED
BY DR. ELSIE HELSEL, WASHINGTON REPRESENTATIVE

Mr. BAIRD. Mr. Chairman, I am John Baird, national field representative for United Cerebral Palsy Associations, Inc., and I am from Miami, Fla.

With me is Dr. Elsie Helsel, who is UCP's Washington representative, and a parent of a cerebral palsy son.

The United Cerebral Palsy Associations, Inc., appreciate very much the opportunity to appear here today in enthusiastic support of H.R. 14237, the Developmental Disabilities Services and Facilities Construction Act of 1969.

The need for such legislation is obvious. Despite advances in the construction of facilities and in the provision of services during the past decade, there remain substantial gaps in service programs, especially for the severely and multiply disabled individuals whose diagnostic label is not "mental retardation" but whose needs are closely related and who require services similar to those needed by the mentally retarded.

We see this as interstitial legislation, filling in the service gaps between established public and private services for the handicapped, and picking up the individuals who have fallen between the service cracks—we have referred to these individuals as "lost pigeons" because they do not fit neatly into established diagnostic and programmatic pigeonholes.

We see in this legislation the opportunity for the development of services for two categories of cerebral palsied individuals who have been left out, screened out, regulated out, or dropped out of practically every public service authorized to date:

(1) those individuals who are mentally retarded and cerebral palsied and nonambulatory;

(2) those who have average mentality but are so severely handicapped physically by cerebral palsy that they cannot make their own way in our society.

United Cerebral palsy has been attempting to serve these individuals and, at the same time, develop techniques so that these persons can be integrated with their peers into other tax-supported programs wherever possible. However, we cannot do this job alone. We need the kind of help that this legislation would offer.

We should like to commend the committee for having recognized that gaps and inequities do exist in present programs and that certain groups of disabled individuals share common service needs. It is courageous, we feel, to draft legislation with a broader, more flexible, decentralized approach to services that focus on the needs of disabled people.

LANGUAGE OF THE BILL

We are particularly pleased with the language chosen to describe the group of individuals to be served by the bill, namely the developmentally disabled. We think this choice of language represents an important advance in the thinking and knowledge of the needs of seriously disabled individuals. It represents progress in the realization that agencies with a categorical focus can work cooperatively to provide the comprehensive programs that are required.

We believe this language will encourage the development of more effective, coordinated and consolidated service programs whose primary purpose is to serve individuals with related needs, rather than to serve diagnostic labels, such as cerebral palsy or mental retardation. In view of our growing knowledge and experience, we now know that such labels tell us nothing about either the program needs of individuals or the services which must be developed to meet these needs. We now know that program needs of the cerebral palsied and the mentally retarded are frequently quite similar. Some programs for these two groups can be effectively combined. Others must be developed separately.

We do not share the concern of some that the use of the broader term "developmentally disabled" will open up services to large numbers of individuals not intended for services under this bill. United Cerebral Palsy has for years opened its Developmental Day Care Centers to those seriously handicapped individuals for whom there was no other appropriate service in the community. We have not been overwhelmed nor overrun.

Concern has been expressed particularly about the numbers of individuals who are not mentally retarded who could become eligible for services under this bill. Although estimating the numbers of developmentally disabled, as defined in the bill is hazardous at this stage, we can estimate the number of persons with severe physical disabilities who are mentally capable in the United States. Based on a study in California, whose primary focus was the provisions of residential services, we understand there may be about 33,000 mentally alert cerebral palsied persons in the United States at the present time who need and cannot get such services as are delineated in the bill, namely: day care, sheltered employment, protective services, and special living arrangements.

We are satisfied that the bill's protective limitations in the definition of the developmentally disabled are adequate to restrict services to the group intended—those whose condition originates in childhood, is expected to continue throughout life, constitutes a substantial handicap to the individual, and for whom services are not available through any other resource.

To ensure that the broadened language does make it possible to include those individuals who are not mentally retarded but who are severely disabled by cerebral palsy, we would like to respectfully suggest some minor technical changes in the bill language that we feel reinforce the stated intent of the bill: "to assist States in developing a plan for the provision of comprehensive services to persons affected by mental retardation and other developmental disabilities originating in childhood."

These are included in the summary on the first page of this testimony. (See p. 288, this hearing.)

We should like also to urge that the present language in section 134(4)(A) be retained. This section is concerned with the requirements for State plans if they are to be approved by the Secretary for funding under this Bill. Section 134(4)(A) states:

The State plan must—

(4)(A) Provide for the furnishing of a range of services and facilities for persons with developmental disabilities associated with mental retardation.

(4)(B) Specify the other categories of developmental disabilities which will be included in the State plan.

The provision under (4)(B), plus the provisions in section 132(a)(1) to permit a State that provides facilities and services for disabilities, in addition to the mentally retarded to enjoy a proportionate increase in its allotment, will, we believe, encourage States to broaden their coverage to include severely disabled who are mentally capable.

Unfortunately, in S. 2846, a bill similar to this, which was passed by the Senate April 13, the phrase "which if any" was added so that section 134(4)(A) now reads: "specify, which if any, other categories of developmental disabilities will be included in the State plan."

We feel this phrase connotes that States are not actually expected to include other categories such as the nonmentally retarded, severely disabled cerebral palsied in their State plans. The inclusion of such a phrase will make the task of our State affiliates more difficult as they press for inclusion of the cerebral palsied in the State plans.

Indeed we have difficulties enough at present in securing services for the mentally retarded, but nonambulatory, cerebral palsied individuals who clearly have been authorized for services under the existing legislation. They are being constantly regulated out of services because of nonambulation. We know the nonambulatory person with cerebral palsy is far more difficult to serve than the individual who is ambulatory. However, UCP has made many nonambulatory persons mobile by putting them on wheels—in wheelchairs, in chairs used primarily by arthritics, in litters and other similarly adapted devices. We have amply demonstrated that such mobile individuals can be included in services with their ambulatory peers. Unfortunately, this group as a whole is hardest hit by lack of services, and has always been low man on the totem pole for funds.

If these unserved categories of individual with developmental disabilities are not included in State plans, it will result in further fragmentation of services and competition for funds. Agencies serving people who are currently excluded from services for the mentally retarded are, of necessity, compelled to develop parallel programs. Thus, while meeting the needs of a special unserved group of individuals, these agencies are often charged with duplicating already existing services.

UPDATING STATE PLANS

In connection with updating State plans, we realize that it will take time to reactivate the State Advisory Citizens' Committee and

update State plans, and that in the interim States will probably have to continue with the plans they already have. We would urge all speed in requiring that State plans be updated. Most of these (except for construction plans) were drafted in the period 1963-1965 and have not been updated since. Also, Public Law 88-156 required that these plans be concerned only with the mentally retarded. There is much we have learned in the past 5 to 7 years, and this new knowledge should be reflected in the State plans. For example, we have learned that many retardates need not be institutionalized when adequate community services are available.

We have also learned when retardates cannot live with their own families that small, homelike, community based residences are preferable to large impersonal, isolated institutions. We have learned that many retardates can be trained to hold jobs in the competitive labor force and that many more can earn part of their own way in sheltered workshops.

COMPREHENSIVE RANGE OF SERVICES TO BE COVERED

We would like to commend the committee for its wisdom in defining "services" so that, at long last, it will be possible to provide a truly comprehensive program for persons with developmental disabilities. This will make it possible to fill the gaps which have accrued because of our hitherto fragmented approach to services. Seriously disabled individuals and their families have a continuum of need throughout their lives. It is both costly and inefficient to provide excellent services during the school years, for example, and then not follow through with workshops or meaningful work activity programs for adults. It is wasteful to provide very costly therapy programs for children up to the age of 18 or 21 in order to achieve maximum functioning, and then, because there is no maintenance therapy service, to permit the person to retrogress, to allow his contractures to take over, and to watch him become a total bed care case because there is no encouragement for self care.

ADDITIONAL SERVICES NEEDED

We should like to suggest the addition of just two services to those already listed: (1) transportation, and (2) follow-along services. Transportation is both a vital necessity and a major problem in providing services for people with multiple handicaps. Indeed, UCP has learned that if these persons are not transported to services they often cannot be serviced at all. At the same time, transportation services often cost our affiliates as much as one-quarter to one-third of their entire budget. In New York City, for example, it costs \$250,000 annually to transport some 300 persons to services and centers. In my own city of Miami, UCP is spending \$20,000 on transportation for 30 children. If transportation costs were included in H.R. 14237, UCP affiliates could release relatively large sums to expand existing programs, add new ones or provide services for more children and adults.

With the committee's permission, I would like to explain what is meant by information, referral, and follow-along services, and why we believe they are essential to any comprehensive program for individuals with serious handicaps. We at United Cerebral Palsy have found frequently that the developmentally disabled and their families cannot thread their way through the maze of services available.

We also have found that an agency will frequently drop these individuals from a service because it is inappropriate or when the agency finds that it cannot manage such a severely disabled person. When there is no immediately obvious service to which the family may be referred, the individual falls "between the cracks" of the services and gets lost, sometimes for years.

Information and referral are not enough. The other element, "a follow along" component, is vital. Essentially, it is a lifetime partnership between the agency and the severely disabled individual and his family which must be established to avoid crisis situations and to ensure that services continue. Even if at some period there are no organized services to meet needs, continuity of contact with the individual and his family should be maintained.

DEFINITION OF CEREBRAL PALSY

Cerebral palsy is the general term applied to a group of disabilities caused by injury or damage to the developing infant brain. It results in impaired muscle control and function. However, this is not a single disability and almost never occurs alone but in combination with other problems. About two-thirds of the cerebral palsied are also mentally retarded; one-half have speech and communication problems; about one-third have visual disorders; one-fifth have hearing difficulties. An undetermined number have learning difficulties associated with perceptual and conceptual problems.

Not everyone with cerebral palsy has all these defects. One in seven may be so little affected that he requires no special assistance. Others are totally incapacitated. Most have a combination of symptoms. They need planned, coordinated treatment and training, much of it extending over the greater part of their lives.

They need services that cost more than most families can afford, a multiplicity of service programs that no single health agency can provide, such as: physical, occupational, speech and hearing therapies; special education programs; developmental and day care centers; vocational guidance, training, work-ready programs; employment; social and recreational activities; eye care; special dental care; braces; drugs; sometimes surgery; and ongoing medical supervision. Nearly all need special transportation if they are to get to available services.

But with cerebral palsy, it is not just those who are handicapped who need help. Parents and families need help too: counseling and guidance; instruction in how to care for a handicapped child; supportive services to maintain home and family stability during crisis periods.

HISTORY OF UNITED PALSY ASSOCIATIONS, INC.

When UCPA was founded in 1949, affiliates stressed treating what was physically correctable—through physical, occupational, and speech therapy, with braces or surgery—and learning. Reluctant public school authorities were persuaded to accept cerebral palsied children in existing facilities, where possible. United Cerebral Palsy established special education classes when necessary and pioneered many advances in this field.

Recognizing that therapy programs focused primarily on improving physical impairments failed to benefit many led to a broadening of emphasis. Some groups organized recreation programs for children and adults. Others started sheltered workshops for those whose disabilities prevented them from working in a competitive environment.

The knowledge that cerebral palsied children lag in development behind normal youngsters has more recently stimulated the establishment of pre-nursery, nursery, preschool and developmental centers. Many of these special "headstart" programs for children with multiple handicaps successfully work with youngsters of 18 months and even younger. Concern for more severely disabled adults—and their families—has led to day care programs for adults, organized services to provide relief for overburdened families. There are also work and social activity programs.

At the present time there are 45 UCPA State affiliates and 255 affiliates in local communities, including the District of Columbia. These affiliates offer a wide range of care, treatment and training programs for persons with cerebral palsy. Large affiliates in major population centers provide or support almost every type of service needed. Others purchase services from appropriate local agencies. The aim is to see that services are provided but not duplicated.

But there are gaps in the service programs. As we have pointed out, the mentally retarded, nonambulatory cerebral palsied individual has a difficult time getting services at any time in his life. The mentally alert, severely disabled cerebral palsied child is frequently dismissed from school because he cannot be managed in the particular school situation. At the adult level problems become really acute. Services he received earlier such as therapy, medical supervision, and education are terminated because of age limitations.

Individuals who cannot make their way in sheltered workshops are left with nothing to do day after day after day. At the same time, parents are aging. So the additional problem of special living arrangements becomes critical. Truly, this interstitial legislation will do a great deal to help in this situation.

There is the additional problem of still not reaching all the individuals who need services. Many are unknown because the diagnostic category "cerebral palsy" is not usually reported to health authorities or because of the difficulty in diagnosing the condition. Many severely physically disabled cerebral palsied persons are in institutions for the retarded merely because there is no other place for them. Others who have previously received UCPA services have reached "maximum" age limits and have "graduated into oblivion." In urban ghettos and in rural communities, individuals with cerebral palsy may be isolated and unknown, living out their lives behind closed windows or in front of TV screens, because services are unavailable or unknown to them.

These are the continuing challenges that UCPA faces in an effort to carry out its primary responsibility of meeting the physical, psychological, social and intellectual needs of cerebral palsied children and adults. To deal effectively with the problems requires a partnership with other services, both public and private. We see the developmental disabilities bill as having tremendous potential for helping us to carry on our mission.

HOW THIS BILL CAN HELP THE CEREBRAL PALSID

UCPA has been trying to meet specific problems confronting the developmentally disabled that other agencies have failed to meet or do not care to address themselves to. It has been our policy not to duplicate already existing services that are adequate. We see our role as that of pioneering in new services which are needed and lacking. When such a needed service has been identified, we try first to develop techniques and practices to meet the need. When we can demonstrate to our own satisfaction that the cerebral palsied can benefit from a service and there are sufficient numbers to warrant the service, we then search out the tax-supported agency which most logically should offer it. We have done this with our diagnostic and evaluation clinics, with our therapy programs and with some of our educational programs for the more able cerebral palsied. This policy continually frees UCPA money and staff for new program development.

There are three specific services which this bill could help us to provide: protective services; developmental day care programs for children; services for severely disabled adults.

PROTECTIVE SERVICES

Of the approximately 700,000 cerebral palsied individuals in the United States, about 280,000 are estimated to be within the normal intelligence range. However, about 33,000 of these individuals are so severely physically handicapped that they cannot even work in sheltered workshops. They need help in managing themselves and their personal affairs. For want of a better name, and because of the relationship to existing patterns of similar but not identical services for children and the elderly, we call these protective services.

Protective services are primarily case management services of a social and socio-legal nature. They help individuals maintain themselves in various kinds of special living arrangements rather than being placed in institutions. Protective services assist the multiply disabled to get those community services to which they are entitled. They protect civil and human rights. Protective services also save money, by preventing or delaying long-term institutionalization.

In California, where such a case management services was instituted in 1967 for severely disabled but mentally alert adults, the yearly cost was \$1,700 per client. It would cost approximately \$8,000 per year to maintain such an individual in one of the California State institutions.

The developmental disabilities bill can certainly help in establishing protective services not only for this group, but for the entire group of the retarded who need such services—especially after parents die. A protective services program also should include, for those retarded persons incapable of making their own decisions, a public guardianship program. Parents would no longer be haunted by the question, "What will happen to this child when we die?"

Approximately 420,000 of our cerebral palsied individuals are also mentally retarded. Obviously, this group would stand to gain much by the passage of this bill. Some of this number can, of course, be served by other agencies serving the retarded. However, we have seen mentally retarded individuals with moderate to severe physical handicaps dropped from programs that are otherwise appropriate for them.

The multiply disabled are not only the last to be added to programs as they are developed regardless of whether the programs are educational, training, recreational, sheltered workshops—they are the first to be dropped when budgets get tight.

DEVELOPMENTAL DAY CARE PROGRAMS FOR CHILDREN

During the past several years UCPA has been concentrating its attention on developmental day care programs for severely and multiply involved children. We have learned that if we can place these children into stimulating programs at a very early age, and if we can get them into proper supportive equipment so they can participate in their world and their lessons, they can learn.

We should like to call your attention to the series of pictures attached to our testimony to show what we mean. (See fig. 1, p. 288, this hearing.) The youngster lying on a litter, who sees not much more than the ceiling or the wall of her room, isn't very hopeful material for a teacher to try to teach. Except for brief periods for feeding in the relaxation chair shown in the next picture, this child had been managed from the supine position from the time she was an infant. At our Indianapolis center, it took time to work her up from the position of lying on the litter most of the day to a semierect position, and then gradually to an erect position so that she can sit up, as you can see here in the last picture.

Note the child's head is supported so that her visual field is enlarged and she can see the world around her. Her elbows and trunk are supported and she now has functional use of her hands. She also can make some effort on her own to hold up her head. Her body is in good alignment so that she feels secure in space. You can tell by the expression on her face that this little girl is alert and ready to learn.

USPA has about 3,000 of these children in its developmental day care programs. The cost is about \$1,700 per year per child, including transportation, where the programs are offered on a 5-days-a-week basis. Because of the cost, many of our affiliates cannot afford 5-day programs for this group; nor can they serve all of the children who could profit from such programs. We estimate there are about 10,000 such children in the United States. The developmental disabilities bill would help us reach and teach more of them.

For children as severely handicapped as is this child in the picture, the alternative to providing developmental day care programs in the community is costly and prolonged institutionalization.

For example, in Illinois there are two excellent facilities providing what we consider adequate institutional care for a person so handicapped. The cost of these institutional programs is approximately \$10,000 per child per year. Contrast that with the \$1,700 for which we can program these children at the community level and which permits them to live at home with their families.

SERVICES FOR SEVERELY DISABLED ADULTS

One of the top priority areas for UCPA program development is services for the severely disabled adult. In our centers we have not only severely disabled adults whom we served when they were children, but we are accumulating adults who have been served by other agencies during their school years. These men and women have not been con-

sidered good hopeful potential for training through the Bureau of Vocational Rehabilitation, and they and their parents turn to our UCPA affiliates for services.

Trying to develop programs for severely and multiple disabled adults is a challenging business. The day-to-day management and transportation problems alone are almost overwhelming. In addition to the need for year-round activity and work programs, these adults need a number of other services if they are to be maintained properly in the community in keeping with present-day trends. They need specialized housing and follow-along case management services, protective services and medical maintenance services.

Several affiliates have developed imaginative programs to meet the special needs of this group. Denver, Colo., has pioneered in innovative and unique adaptations of equipment to enable severely disabled adults to work in a sheltered workshop situation. The Columbus, Ohio, center has over 100 severely disabled adults in a combined workshop and work activity program. UCP of New York City has a most interesting developmental program for adults which includes an apartment for training in independent living.

At present we are serving only about 2,500 men and women in some fashion—some in programs scheduled only 1 day a week. Others meet only a few times a month. It is for this group of multihandicapped adults where the need is so great, that the expanded service provisions of the developmental disabilities bill could have a really great impact—special living arrangements, day-care programs for adults, sheltered workshops with adaptations, protective services. All of these services are desperately needed.

LEVEL OF APPROPRIATION

We would like to respectfully suggest that the authorization level for this bill be raised to the level of need. We estimate this to be at least \$100 million for fiscal year ending June 30, 1971 for grants to assist States in developing and implementing comprehensive programs and to assist public and nonprofit agencies in the construction of facilities. We realize that budgets are tight and there is some apprehension that putting in such an authorization level will raise false hopes. However, we feel the committee, which has done such an excellent job of appraising the problem and structuring legislation to meet the need as they see it, should also be realistic in calling for the dollar amount necessary to carry out the purposes of the legislation.

We know we are not going to reach full comprehensive services or fully funded services tomorrow. However, this should be our goal. We hope that we have shown you how money invested in the kinds of programs authorized under this bill will result in tremendous savings in the long run, not only in dollars but in human lives.

CLOSING STATEMENT

In closing, UCPA believes passage and adequate funding of the developmental disabilities bill—H.R. 14237—will make it possible to fill gaps in services for the developmentally disabled and to hasten the day when, working together, the voluntary sector and the State and Federal Governments can provide a comprehensive program to help

children and adults with developmental disabilities—no matter how limited their potential—achieve the most productive life that is possible for them.

That completes my prepared statement, Mr. Chairman.
(The attachments to Mr. Baird's statement follow:)

SUGGESTED CHANGES IN THE BILL

Page 6, line 17—add at the beginning of the line "to."

Page 10, line 2—add at the beginning of the line "with."

Page 23, line 9—after "sheltered employment" add "transportation."

Page 23, line 12—after "referral" add "follow-along services."

Leave unchanged on page 9, lines 21, 22, and 23, section 134(4) (B) "specify the other categories of developmental disabilities which will be included in the State Plan."

FIGURE 1



UNITED CEREbral PALSY ASSOCIATIONS, INC.
66 East 34th Street
New York, N.Y. 10016

Reproduced with permission of:
Southern Regional Education Board, Atlanta, Georgia

Mr. ROGERS (presiding). Thank you very much, Mr. Baird, for an excellent statement. It certainly points up the problem that we need to face in this field and have not been facing very well.

How many new cases each year is it estimated will develop?

Mr. BAIRD. Elsie, could you come up with that?

Dr. HELSEL. Twenty-five thousand babies are born annually with cerebral palsy; one in every 170 live births. We use a figure for the general public of one born every 53 minutes, which would give you some idea of how many new people are "coming aboard."

Mr. BAIRD. Of course, I would be compelled to say here that with the progress in medicine many more severely involved youngsters are being kept alive.

Dr. HELSEL. I think too, Mr. Rogers, that we should say that our priority program effort has aimed in the direction of prevention, early detection and early care. We certainly want to reemphasize what you said yesterday about the importance of prevention, not only in terms of the potential saving of billions of dollars, but also in terms of saving human anguish. Prevention of handicapping conditions is urgent, especially when we know some of the things that could be done if we had the money for necessary programs.

You mentioned rubella. We also are most interested in prematurity, which is an area in which we know some of the things we should do to prevent it, and we do not always do them.

Mr. ROGERS. Could you supply for the record some of the advancements made and some of these things that ought to be done. And maybe you could outline for us generally to what extent they are being used or are not being used.

Dr. HELSEL. I would be glad to do this.

Mr. ROGERS. I think this would be helpful.

(The following letters were received for the record:)

UNITED CEREBRAL PALSY ASSOCIATION, INC.,
New York, N.Y., June 12, 1970.

Re hearings on development disabilities bill H.R. 14237.

Mr. JAMES M. MENDER, Jr.,
Professional Staff Member, House Committee on Interstate and Foreign Commerce, Rayburn House Office Building, Washington, D.C.

DEAR Mr. MENDER: You will recall that following the statement of Mr. John Baird, United Cerebral Palsy Associations' national field representative, Congressman Rogers asked that we supply certain additional information for the Committee.

Enclosed you will find our Fact Sheet giving statistical data on estimated number of births and incidence of cerebral palsy in the United States. In addition are materials illustrating what this organization is doing to educate the medical profession about one of the major causes of cerebral palsy: prematurity.

Identification of "high risk" mothers is very important to this organization because these women are most apt to give birth to damaged babies. Thus, we are concerned with maternal malnutrition, have cosponsored conferences for social workers on mothers-at-risk and a few of our affiliates have embarked on local programs to follow-up these women. Materials in this area are also enclosed.

More recently, the UCP Research and Educational Foundation has redirected its support or research investigations to emphasize the prevention of this crippling disorder. A descriptive outline is included. Since September 1969 nine research projects have been approved for funding, all related to cerebral palsy prevention. A listing of these projects is currently being prepared, and I shall see that a copy is sent to you as soon as it is completed.

Thank you for your interest. If you should have additional questions relating to our statement of June 10, or if we can be of further assistance regarding H.R. 14237, please let us know.

Very truly yours,

RITA A. BUNIN,
Press Information Director.

Enclosures.¹

UNITED CEREBRAL PALSY ASSOCIATIONS, INC.—FACT SHEET

What is cerebral palsy?

Cerebral palsy is a condition caused by damage to the human brain, usually at birth. "Cerebral" refers to the brain and "palsy" to lack of control over the muscles.

What are the effects?

In addition to lack of motor control, there may be seizures, spasms, mental retardation, abnormal sensation and perception, impairment of sight, hearing and speech, all in varying degrees.

What are the causes?

Any damage to brain tissue, whether caused by defective development, injury or disease may produce cerebral palsy.

Chief among the causes is an insufficient amount of oxygen reaching the infant's brain. Interruption of the oxygen supply can result from premature separation of the placenta from the wall of the uterus; an awkward birth position; labor that goes on too long or that is dangerously abrupt; and a squeezing or other interference with the umbilical cord. Other causes may be premature birth, Rh or A-B-O- blood type incompatibility between parents, or infection of the mother with German measles or other virus diseases in early pregnancy.

Are there different kinds?

Three main types of cerebral palsy are the *spastic* individual who moves stiffly and with difficulty, the *athetoid*, who has involuntary and uncontrolled movements, and the *ataxic* whose sense of balance and depth perception is disturbed. Further classifications are made depending on the area of involvement.

How many persons have cerebral palsy?

Some 750,000 children and adults in the United States have cerebral palsy; more than 250,000 are under 21 years of age. Every year over 25,000 infants are born with the condition. Cerebral palsy occurs in 1 out of every 176 live births.

Can it be prevented?

Yes, some measure of prevention are possible today. Pregnant women are routinely tested for the Rh factor so that if there is blood incompatibility the baby can be protected by exchange transfusion. Other preventative programs are directed toward reducing congenital malformation, prematurity, unnecessary exposure to X-rays, and controlling diabetes and anemia.

How is it treated?

Since cerebral palsy is not a progressive disorder that can be arrested, treatment consists in helping the child in growth and development. This usually requires programs of physical, occupational, speech and hearing therapy.

Surgery is used in some cases to control nerve and muscle coordination. Through orthopedic surgery, foot, leg, hand and arm movements have been improved.

Braces are used to reinforce a muscle in certain types of cerebral palsy, and to prevent or correct deformity.

What is the cost of cerebral palsy?

The annual estimated cost of care and rehabilitation for the 750,000 children and adults with cerebral palsy is \$500,000,000.

Estimated number of persons with cerebral palsy in a community

Population:	Number with CP
5,000-----	20
10,000-----	40
50,000-----	200
100,000-----	400
500,000-----	2,000

¹ The UCPA "Fact Sheet" and the UCPA, Research and Educational Foundation, Inc., descriptive outline are printed in this hearing. The additional material referred to may be found in the committee's files.

What is United Cerebral Palsy Associations?

UCPA is a national voluntary health agency formed in 1949 to develop and carry out programs of patient services, public and professional education and research in cerebral palsy. Among its founders were many parents of those afflicted.

How is United Cerebral Palsy Associations organized?

There are 300 affiliates in 45 states. In 1969 an estimated 300,000 volunteers devoted their time and energies to the cause, assisting in all facets of affiliate services.

What are its services?

At the local level, direct services are provided by affiliates to cerebral palsy victims and their families. These include: medical diagnosis, evaluation and treatment; special education; vocational training, recreation, and parent counseling.

On the national level, United Cerebral Palsy's research and training programs are carried out through its Research and Educational Foundation, established in 1955. To date, more than \$10,000,000 has gone to support research into the causes, prevention and treatment of cerebral palsy. Fellowships and scholarships are also awarded to reduce the serious shortage of scientific and professional manpower in this field. These support the training of investigators, physicians, educators, therapists and medical students.

* * *

UNITED CEREBRAL PALSY ASSOCIATIONS, RESEARCH AND EDUCATIONAL FOUNDATION,
INC., NEW YORK, N.Y.

The United Cerebral Palsy Research and Educational Foundation recently decided to restrict its financial support to a task force effort in certain areas of direct relevance to cerebral palsy. These areas include:

1. Prematurity—its prevention and neuromotor consequences.
2. Obstetrical and paranatal factors resulting in cerebral palsy.
3. Neurotropic viruses (fetal and postnatal) associated with significant neuromotor aftermath.
4. Hyperbilirubinemia of the newborn—methods of prevention and therapy.

In addition to the approaches of the task forces, the Foundation will give serious attention to formal applications for research in the above areas. Careful consideration will also be given to support research in other areas of prevention and therapy bearing directly on the cerebral palsy problem.

A small grants program (maximum \$2,500, plus 15% overhead) will be continued to maintain flexibility and to permit immediate initiation of any especially innovative, meaningful research.

Applications for research support satisfying the above criteria, may be obtained on request from the United Cerebral Palsy Research and Educational Foundation, 66 East 34th Street, New York, N.Y. 10016.

The deadline date for submission of applications is July 15, 1970 for funds available as of January 1, 1971.

UNITED CEREBRAL PALSY ASSOCIATIONS, INC.

New York, N.Y., June 19, 1970.

Re H.R. 14237, hearing on developmental disabilities.

Mr. JAMES M. MENDER, Jr.,

Professional Staff Member, House Committee on Interstate and Foreign Commerce, Rayburn House Office Building, Washington, D.C.

DEAR MR. MENDER: The enclosed listing of United Cerebral Palsy Research and Educational Foundation grants, plus the index of grants for research grants which appears in our 1969 annual report completes the material Congressman Rogers asked us to provide for the record on the hearing for H.R. 14237, The Developmental Disabilities Services, Facilities and Construction Act. Please note that the projects directed toward the prevention of cerebral palsy have been checked.

Please let us know if there is anything further we can do to assist you or your staff in developing the report.

Sincerely,

RITA A. BUNIN,
Press Information Director.

ATTACHMENT A

GRANT APPLICATIONS REVIEWED BY RESEARCH ADVISORY COUNCIL, UNITED CEREBRAL PALSY RESEARCH & EDUCATIONAL FOUNDATION, INC., APR. 26-27, 1970

Recommended for funding		Period of grant	Total approved	
Investigator and institution	Title of grant		By fiscal years	
Abrams, Israel, M.D., Children's Hospital, Boston, Mass.	Neurological problems in the newborn as they relate to cerebral palsy.	July 1, 1970 to June 30, 1973	\$96,077	1970, \$37,543; 1971, \$27,657; 1972, \$30,877.
Eichenwald, Heinz F., M.D., the University of Texas (Southwestern) Medical School, Dallas, Tex.	Viral infection of early infancy as cause of permanent central nervous system dysfunction.	do	48,498	1970, \$15,361; 1971, \$16,166; 1972, \$16,971.
Garner, Lawrence M., M.D., Albert Einstein College of Medicine, Bronx, N.Y.	Phototherapy effects on bilirubin metabolism, plasma, protein binding of bilirubin, physical growth and neurological development in low birth weight infants.	July 1, 1970 to June 30, 1971	26,070	1970, \$26,070.
Johnson, Richard T., M.D., Johns Hopkins School of Medicine, Baltimore, Md. ¹	Effects of perinatal virus infections on the developing nervous system.	July 1, 1970 to June 30, 1973	127,978	1970, \$53,177; 1971, \$38,468; 1972, \$36,333.
McDonald, Eugene I., Ed. D., Home of the Merciful Saviour for Crippled Children, Philadelphia, Pa.	Exploration of the feasibility of employing programmed learning and an automated self-instruction system in the education of cerebral palsied children of average or better than average learning ability who have handicapping involvement of the upper extremities.	Sept. 1, 1970 to Aug. 31, 1971	26,200	1970, \$26,200.
Quilligan, E. J., M.D., Woman's Hospital, Los Angeles, Calif. ¹	Cerebral blood flow and distribution in the in-utero sheep fetus.	July 1, 1970 to Dec. 31, 1971	27,338	1970, \$25,225; 1971, \$12,113.
Schmid, Rudi, M.D., University of California, San Francisco, Calif. ¹	Light treatment of neonatal hyperbilirubinemia: chemical and physiological characterization of the photoderivatives of bilirubin in vivo.	Sept. 1, 1970 to Aug. 31, 1971	43,308 ²	1970, ² \$43,308.
Schiff, David, M.D., Ph. D., McGill University, Montreal Children's Hospital Research Institute, Montreal, Canada. ¹	Studies into carbohydrate metabolism in the newborn	July 1, 1970 to June 30, 1971	20,700	1970, \$20,700.
L. Stanley James, M.D., College of Physicians and Surgeons, Columbia University New York, N.Y. ¹	Maternal and fetal stress and the onset of labor	do	27,300	1970, \$27,300.
Total grants approved			453,469	1970, \$274,884; 1971, \$94,404; 1972, \$74,181.

¹ Projects directed toward the prevention of cerebral palsy.² Subject to negotiation of amount.

Mr. ROGERS. Mr. Preyer?

Mr. PREYER. Thank you, Mr. Chairman.

I find your statement very interesting, and particularly the need for the follow-along program. It is a very dramatic discussion of how CP people too often "graduate into oblivion," as you say. That is a sad situation.

Also I thought your specific example on page 13 was excellent, how by a yearly cost of \$1,700 a patient you can save \$8,000 per patient for State institutional care. Any examples of this kind that we can bring out are very helpful.

Dr. HELSEL. You might be interested that this particular experiment was entered into by the State of California. They invested half a million dollars in a study project to search out how to manage these people. They thought they wanted to build an institution for this particular group. What came out of their project was the finding that they did not need an institution but do need follow-along care.

Mr. BAIRD. In Florida, for example, we have developed basically through the retardation area the half-way houses, on which we are now just gathering information as to the cost to compare with the known State institutionalization, a wide-open area in this direction.

Dr. HELSEL. This is again an area needing research—alternatives to institutional care—half-way houses, hotels, nursing homes, small group homes. There are many of these services-related areas in which we need more information but that we have not had the money to explore.

Mr. Kyros yesterday was asking about the services for rural areas. We instituted a series of projects with the Fraternal Order of Elks—cooperative arrangements between the Elks and UCP in which we establish home service units. This service involves a station wagon with a professional person, such as a nurse, a teacher, or a social worker, someone with professional competence going into the rural areas to work with the family, to assess the problems, to see whether they are getting the services they need, to take them into the clinics in the towns, to do all the kinds of things that our severely handicapped children need. The home service worker demonstrates the kinds of early stimulatory activities a mother should be using with a handicapped child. If this child does have to be institutionalized, the UCP home service worker helps the family in taking that step.

Now, I think this is the answer to some of our rural problems. But again, we just have a beginning here and there where we really need a blanket kind of program. However we have not really had a way to initiate it.

Mr. PREYER. Thank you for your very helpful testimony.

Mr. ROGERS. Thank you very much. And we will go over these suggested amendments and consider them very carefully.

Mr. BAIRD. We will appreciate it.

Mr. ROGERS. Thank you, Mr. Baird, we appreciate your help.

And thank you, Dr. Helsel.

Our next witness is Mr. Maurice G. Kott, director of the Division of Mental Retardation, Department of Institutions and Agencies, the State of New Jersey.

We are delighted to welcome you to the committee, Mr. Kott. And we would be glad to have your testimony for the record, and pleased to hear your testimony at this time.

Please proceed in your own way, sir.

STATEMENT OF MAURICE G. KOTT, PH. D., DIRECTOR, NEW JERSEY DIVISION OF MENTAL RETARDATION, DEPARTMENT OF INSTITUTIONS AND AGENCIES, AND REPRESENTATIVE OF THE NATIONAL ASSOCIATION OF COORDINATORS OF STATE PROGRAMS FOR THE MENTALLY RETARDED

Mr. KOTT. Mr. Chairman, members of the subcommittee, my name is Maurice G. Kott, director of New Jersey's division of mental retardation. I am here today to represent the State of New Jersey and the National Association of Coordinators of State Programs for the Mentally Retarded. This association is organized for the purpose of conducting educational and scientific activities pertinent to the field of mental retardation. Its regular members are the duly constituted State officials in charge of public mental retardation programs in the various States. The president of our association, Dr. Charles D. Barnett, commissioner of the South Carolina Department of Mental Retardation, asked me to express regrets but pressing business both of a personal and a public nature precluded his appearance here today.

Perhaps I should say a word more about the National Association of Coordinators of State Programs for the Mentally Retarded so that I may convey to you our sense of investment in the legislation which you are presently considering. The association consists of a single individual from each of the several States who has been designated by the Governor to coordinate mental retardation within the State.

In the instance of your State, Mr. Rogers, the representative member is Dr. James Foshee.

The individual who is designated as a member of this association has preeminent responsibility for the delivery of services to State citizens handicapped by virtue of retardation. The public retardation programs that are the concerns of this association encompass non-residential and residential services, provided in each of the States in order to meet the needs of the mentally retarded and their families.

We have not taken the time to total the State funds collectively administered by our members, but it is surely in excess of one and a half billions. The 1971 budget for the division I represent is in excess of 37 million, exclusively funds available for capital purposes.

This amount is twice the operating budget of 10 years ago, and does not obviously include State and local funds expended on special education, rehabilitation, employment security, and the other kinds of service so essential to the retarded.

The growth is not exclusively to be found in expenditures on residential care. In the same 10-year period the amount of State dollars in the New Jersey Division of Mental Retardation expended for community services has increased from approximately one-third of a million dollars to an amount in excess of two and a quarter millions. This escalation of funds for community services is paralleled by similar increases in education, rehabilitation and other activities avail-

able and conducted where the mentally retarded and their families live.

My purpose here today is to make three points. The first involves the impact of past Federal legislative manifestations and my perception of the implication of future Federal legislation. The second point I wish to make involves the significance of the level of future Federal funding. My testimony will conclude with my opinions on the meaning to the States of the manner in which Federal grants are made available to the States.

For those of us who have worked in the field for a relatively long time—and I have for about 30 years—three significant events have occurred since 1949. The first was the organization of the National Association for Retarded Children and its various State components.

This association of parents and friends of retarded persons is responsible to a great extent for clarifying the needs of handicapped individuals and has served as primary force in lifting services to retarded persons from the doldrums in which they existed during the 1930's and 1940's. The second significant event was the statement of a proposed program for "National Action to Combat Mental Retardation," reported to President Kennedy by his Panel on Mental Retardation in October 1962. This report delineated, to my knowledge for the first time, a comprehensive conception of national responsibility for the prevention, treatment and amelioration of mental retardation. It defined the national goal regarding health care, guidance, special education, vocational rehabilitation and preventive services which must be provided the retarded.

In addition, it established the parameters of the task of providing adequate and approved facilities for retarded individuals who must be maintained in institutions.

The third event was the enactment of Public Laws 88-156 and 88-164, which in the first instance provided Federal stimulation and support for State level comprehensive planning to combat mental retardation, to implement the national conceptions expressed by the President's Panel on Mental Retardation.

As a consequence, every State now has a plan to combat mental retardation. In the 5 years since most of these reports were written State and local jurisdictions have begun to move.

Public Law 88-164 provided for Federal support to the States for development of facilities wherein appropriate services for the mentally retarded could take place. Every coordinator of State programs for the mentally retarded knows that buildings of and by themselves do not make good programs nor assure adequate services. In the absence of the structures which have been developed as a result of Federal impetus through the 88-164 mechanism, we would have been attempting to provide services in physical structures which would have hampered the efforts of a competent and willing staff. The document "Mental Retardation—Construction Program," produced by the Secretary's Committee on Mental Retardation of the United States Department of Health, Education, and Welfare, indicates that as of December 31, 1968, Federal funding was associated with the development of 116 facilities sponsored by nonprofit organizations, and an additional 107 facilities under public sponsorship.

As a result of the stimulation provided by this part of Public Law 88-164, a total of 63,119 mentally retarded persons are being served, who had not been served previously or had been served previously in inadequate or unsatisfactory circumstances.

Perhaps I can participate by revealing the impact of this legislation on New Jersey. Day training centers for children of school age, who are so handicapped that they are considered neither educable or trainable by the public schools, had been established as early as 1960 by components of the New Jersey Association for Retarded Children. These energetic innovators attempted to provide a new service for extremely handicapped children in church basements, factory lofts, and other structures, which were ill suited for the severely retarded, and which frequently impeded child growth and staff efforts. As a result of State appropriations, elicited in part by anticipation of the allocations to New Jersey under Public Law 88-164, new facilities now exist for 488 mentally retarded in contrast to the 275 who were served by this program in 1966. The total number of children in this program at the present time is in excess of 600.

As a result of the above-mentioned stimulation all States have systematically reviewed their service and capital needs, have proposals to remedy structural defects which impede programs in residential facilities, have planned for expanded facilities to meet the needs of those awaiting admission to residential facilities and for community oriented programs so that nonresidential services may be available throughout each State. It would be erroneous, however, for me to address myself exclusively to the impact of Public Law 88-164 with respect to construction of facilities to provide services to the mentally retarded. The provisions of that act which fostered university-affiliated construction programs and subsequently provided service implementation by way of staffing grants were greeted by State administrators with equal enthusiasm. We recognize that the university-affiliated program can become a focal point for the training of a wide range of professional and technical personnel. And staffing grants have enabled innovation and expansion of services under both nonprofit and public sponsorship to a degree that would have been unlikely or impossible in the absence of Federal encouragement.

The impact of the staffing grant program may be illustrated by the New Jersey experience. In the first year, 1969, eight grants have been awarded to nonpublic agencies, in anticipation of new or expanded community mental retardation services. These first-year grants just scratched the surface of the possibility of service to the retarded, and despite the triteness of the phrase, are "just a start."

Incidentally, the programs have come about as a result of New Jersey ARC interest and local voluntary commitment. The largest grant, for instance, was to the Mount Carmel Guild of the Archdiocese of Newark for the purpose of initiating a multiservice center in a poverty stricken, overcrowded, ghettoized area defined by Federal criteria as a "model city."

Despite the rapid progress made in recent years and the impetus given to services by way of the Federal manifestation of concern for retarded people, it seems to me that we are at an important turning point at the present time. Legislation before the Congress can have a tremendous effect upon whether the momentum given to programs for

the retarded will be sustained. I am certain that members of the subcommittee are aware of the needs for retardation services which have remained unmet at this point in the various States. What is required is enactment of legislation which will permit the continuation of planning, administration, technical assistance, service initiation, and construction relative to mental retardation services.

It does seem to me, however, that more than mere continuation must be assured. The recent level of Federal appropriations has been acutely disheartening to those of us who work in the States and have an intimate view of the numbers of unserved cases and a sense of the unmet individual human needs. I would suggest that the level of authorization included in S. 2486 for fiscal years 1971 through 1973 be considered minimal. If I may, again, call upon New Jersey as illustrative of the extent of need throughout the country, the suggested level of authorization in S. 2486 for fiscal 1971 at \$100 million is minimal when one considers that New Jersey needs \$90 million in order to accommodate the waiting list, to complete the program of construction of day training services in the various counties of our State, to erect some smaller facilities in our largest cities—as a specialized residential opportunity for persons who do not need the larger congregate residential facility—and to renovate its older institutions to an acceptable standard. Please consider further that the \$90 million figure for New Jersey represents residual need following a State commitment of approximately \$50 million for construction authorized since 1964.

You will note that here again I have addressed myself preeminently to construction. Some service programs outlined in each of the 50 States' plans to combat mental retardation have yet to be initiated. Others remain to be fully realized. In the absence of a real manifestation of Federal support, through adequate levels of authorizations for both service and construction, the implementation of plans will fall farther and farther behind, and the aspirations of parents, professionals, and the coordinators of State programs for the mentally retarded will not materialize.

My final point is to be my position in regard to the manner in which Federal grants should be made to the States. If States have developed adequate comprehensive plans and if it makes sense to integrate the administration and implementation of a comprehensive State plan at a local level, a formula award has many advantages over a project grant approach. Perhaps it would be simplest for me to put it this way, I have no objection and, indeed, see certain merits to the reservation of a certain percentage of an appropriation for project grants for "special significant projects." In general project grants, however, fail to recognize State comprehensive planning—which, incidentally, was nurtured by previous Federal support. Control by way of the project grant mechanism may imply that the conceptions resulting from the planning process may be too inadequate or erroneous to be funded in a manner determined by State administrations.

The concept of the project grant, with its attendant regulations and definitions, fails moreover to take into account wide differences among the States. Finally, State agencies and State legislatures are better able to develop sound on-going programs with stable support to look forward to over a period of time. Such long term commitment is not offered by way of the project grant mechanism, but exists where a

State agency has full power to determine allocation of Federal grants, after priorities are established in an approved State plan.

On behalf of the National Association of Coordinators of State programs for mentally retarded, may I thank the subcommittee for the opportunity to appear. I shall be happy, moreover, to attempt to answer any questions you my wish to put to me.

Mr. ROGERS. Thank you, Mr. Kott, for your statement and the specific information on how the State is affected. It is very helpful.

Mr. Preyer?

Mr. PREYER. Thank you.

You point out that you favor a formula award over a project grant approach. And you have given some good examples from New Jersey as to how your State comprehensive planning is working. Apparently it is working well. Is this true in most of the other States? Have we gotten far enough along with our State comprehensive plans to switch from a "project grant" approach to a "formula" approach?

Mr. KOTT. Mr. Preyer, it is my opinion that that is so. I do not have personal knowledge of each of the 50 States, but many of those of which I do have knowledge have indeed formulated plans, have indeed created executive bodies that are in effect keepers of the State plan and whose responsibility is to see that it is implemented. I do not think the situation I described is unique in New Jersey.

Mr. PREYER. You are speaking, then, on behalf of the National Association of Coordinators of State programs in this respect rather than just for New Jersey?

Mr. KOTT. I am, sir.

Mr. PREYER. Thank you very much.

Mr. ROGERS. Mr. Kott, Assistant Secretary Black yesterday said that only about 20 percent of the centers were in the rural poverty areas, urban or rural. And he seemed to think that if we would turn to project grants that the Federal Government could do a better job in getting to those areas where most of the retardation dwells, I think that is the theory.

Do you think it is true that the States can't or won't deliver the necessary services to those poverty areas?

Mr. KOTT. I certainly do not think, Mr. Rogers, that it is true that the States will not. I think there are problems associated with the delivery or services in the urban areas and the poverty-stricken areas. I do not think these problems will disappear in the presence of a Federal control over the granting mechanism.

May I elaborate on that for a moment, sir?

Mr. ROGERS. Yes.

Mr. KOTT. Some of the problems which exist—and perhaps I can again exemplify some of our difficulties in New Jersey, although I think we have been somewhat successful in the placement of these programs in the poverty areas—are of this character. The poverty areas are the most urbanized areas of the State, and property often by itself as space for facilities is most difficult and most expensive to acquire.

Secondly, the local government is frequently less than enthusiastic about the loss of ratables.

Thirdly, there is a problem associated with urbanization, particularly when you are dealing with a group as handicapped as a day

care group. You must transport them. And you do have problems in arranging transportation in our congested cities.

There is, of course, an additional factor. Sometimes the residents of the urban areas are less than enthusiastic themselves about the development of certain services, because they see a clear need for housing. And one of our experiences was that a site, which was identified in downtown Newark, was in effect given up because it was conceived more necessary to develop a housing project, rather than take 5 acres away from that area for day training services, rather than to provide day training services.

I think there is another factor which in general is of significance here. We are dealing with a number of kinds of retardation, sir. There probably is a higher incidence of mental retardation in the ghetto areas. But it is a different kind of retardation. It is not the retardation associated with the severe kind of handicap that is reflected in many of our residential population or in our day care. And this population, the more mildly retarded, the culturally based retardation, may be well cared for by extensive education programs, and by supplementation of rehabilitation programs.

Now, if I can, sir, I would like to particularize some of our attempts in New Jersey to overcome the difficulties.

Mr. ROGERS. I think it might be helpful, since we are pressed for time, if you could let us have a rundown for the record on some of your experiences, and point out these things that you have just developed here specifically, the different types of retardation that must be dealt with, and how this shows up in the poverty areas vis-a-vis the other residential areas, and so forth. If you could do that I think that would be helpful to the committee.

Mr. KOTT. I would be happy to do that. But may I just supplement my answer to your direct questions.

It is my sincere conviction that the States are neither disinterested nor dragging their heels in moving into the significant area.

Mr. ROGERS. Yes, because I would think they are all very conscious that these areas must be serviced and handled.

Mr. KOTT. They all are, sir.

Mr. ROGERS. Thank you very much, Mr. Kott. Your testimony is most helpful. I appreciate your being here.

(The following letter and attachment were received for the record:)

STATE OF NEW JERSEY,
DEPARTMENT INSTITUTIONS AND AGENCIES,
Trenton, N.J., June 12, 1970.

HON. JOHN JARMAN,
*Congressman, Oklahoma, Subcommittee on Health and Public Welfare, House
Committee on Interstate and Foreign Commerce, Rayburn House Office
Building, Washington, D.C.*

DEAR MR. CHAIRMAN: I submit the attached at the request of Congressman Rogers. In the course of the public hearings on future federal funding of mental retardation or developmental disabilities services Congressman Rogers asked whether I would not comment on what I understood was the position of Mr. Creed C. Black, Assistant Secretary for Legislation of the Department of Health, Education and Welfare, with regard to state willingness and ability to serve poverty areas. At the completion of my response, Congressman Rogers asked whether I could not file some elaboration for the record.

If this office or the National Association of Coordinators of State Programs for the Mentally Retarded can be of further service to the sub-committee, you have only to call upon us.

Sincerely,

MAURICE G. KOTT, Ph.D.,
Director, Division of Mental Retardation.

The States do recognize the need for accelerated services to areas in which impoverished and culturally deprived persons live. It is my opinion, moreover, that there is nothing intrinsic in the locus of authority to grant funds which would accelerate the process of serving the retarded in poverty stricken urban areas, whether such authority is given to the states or remains with the federal government. The implementation of plans for such service is difficult for a number of reasons and the difficulties will obtain regardless of project or formula grant mechanism. The factors which make service implementation difficult include:

1. The crowded conditions of cities resulting in limited space available for carrying out service in contrast to the relatively large amount of space available in suburban regions and rural property areas.

2. The cost of land in cities, if construction is contemplated.

3. The preeminent concern of persons themselves living in impoverished urban areas with essentials such as adequate housing and diet.

4. Cities have revenue difficulties. The loss of ratables, even for "good causes", is not greeted with enthusiasm by local administration, and

5. The crowded character of an urban place makes transportation of handicapped people difficult and expensive, particularly if public transportation cannot be utilized because of the location of a service facility or because of the severity of the handicap.

The nature of the question and the above response seem to imply that States have not developed mental retardation services in urban poverty areas. Many have, and such services as have been developed within the impoverished area have been supplemented by services outside but adjacent to urban areas of poverty. The New Jersey experience with day training may serve as an example of adjacent service facilities. Within a short geographical distance, and in terms of time within a reasonable span, two day centers serve the model city areas of Trenton and Camden. Such facilities should be considered along with those actually located in poverty areas.

Of additional significance in understanding the history of development of service to retarded persons in urban places is the fact that while "poverty" contributes disproportionately to the number of retarded, there are distinctions among retarded persons which when recognized suggest corresponding service distinction. The retarded in the cities are of two types, those whose retardation is a function of economic deprivation or the absence of stimulation and those whose handicap stems from such biological or medical factors as are to be found distributed throughout the population without regard for socio-economic identification. The former are the largest number, swelling the incidence of retardation in the cities. They, however, do not require the kinds of services anticipated in the Developmental Disabilities legislation before the Congress and should be served by educational, vocational rehabilitation and similar programs. In these terms, perhaps the attention paid to areas of poverty under the P.L. 88-164 mechanism by States was adequate and proportional.

Since I have made reference to both the difficulties which obtain in placement of services in urban places of poverty and New Jersey's experiences perhaps I can describe some of the events and activities associated with our attempts to place services in new construction in cities. We have for two years sought property in Essex and Hudson Counties through the bureau of state government which is responsible for funding and acquiring land for state purposes.

The Chief of the Bureau of Day Training and the Regional Supervisor of this program have investigated "for sale" signs, newspaper ads and with realtors. Local (both municipal and county) governmental and model city assistance has been solicited. Components of the New Jersey Association for Retarded Children have joined us in this search. One available site was identified in Jersey City; it, however, was partially under an elevated highway and bisected by rail tracks. A second site, in nearby Secaucus was somewhat more desirable but the gap between the asking price and the appraisal by State officials never closed. In Essex County, an original site in Newark and adjacent to intended Medical School construction was lost because the School needed more space and the area residents resented the loss of so large a tract. The use of this downtown site was

one of the expressed issues in the Newark riots. In East Orange, we "found" a small site, but could not assemble a large enough tract, in part because of local resistance to a loss of ratables.

As suggested previously perhaps the solution to this problem of urban location is building nearby and transporting the retarded to it. I do not see it solved by the project mechanism under federal granting authority. As a matter of fact, this latter mechanism may impede the development of services in urban places of poverty since local jurisdictions and organizations in such places frequently have neither the "know how" to propose and manage projects nor the funds to meet matching requirements.

Mr. ROGERS. Our next witness is Dr. Donald Stedman, the associate director of the John B. Kennedy Center for Research and Human Development, George Peabody College, Nashville, Tenn., and director of human development programs at Vanderbilt University Medical Center in Nashville, Tenn.

Dr. Stedman, we are delighted to have you here. Your statement will be made a part of the record at this point, and if you would highlight it it would help because of time.

**STATEMENT OF DR. DONALD STEDMAN, ASSOCIATE DIRECTOR,
JOHN F. KENNEDY CENTER, GEORGE PEABODY COLLEGE**

Mr. STEDMAN. Thank you, Mr. Chairman.

My statement is so brief I think I can read it in a few minutes.

Gentlemen, I am aware that Members of Congress must endure days "crowded with an ever-increasing information overload." I shall try to avoid contributing to that further except for what I believe to be pertinent points that have not been sufficiently emphasized in testimony thus far. I am advocating the passage of H.R. 14237. I sincerely hope that it will move forward and be put to work in the towns and cities of America soon.

Your own background staffing and that of the Senate committee which passed its version has been remarkably thorough and complete—a delightful thing for one with research training. Documentation of the problem has been exhaustive, which had a good array of witnesses. However, there are three areas on which, in my judgment, more must be said in order to place the problem of developmental disability in this country in the proper context; why the increased services to the disabled and their families that would be made possible by this bill are sorely needed, and why the manpower training it would support must be provided.

1. THE FAMILY CONTEXT

Developmental disabilities as defined in the bill should not be seen as limiting only the persons directly affected. The proper context within which to view the problem is within the family as a unit and an organization. One hundred children with developmental disabilities can affect as many as 1,000 people, if you include parents, brothers and sisters, family friends, neighbors, more distant relatives, and those who would try to respond to the family's need for help.

Mental retardation, physical handicaps, epilepsy or other disabilities are chronic. Unless they are discovered early and treated early they can increase their debilitating effects on the child and on the family. They can in fact become more intense as the child grows and ages. After diagnosis or discovery of the developmentally disabled, there are

other problems—in schooling, in training, in adolescent adjustment problems, adequate transition to community life—a problem for all our young people—for the severally affected, problems of guardianship and residential or institutional care.

Therefore, it is not appropriate to say that the impact of this bill through the services it would provide affects only disabled persons, many yet unborn. It also touches their families in a very real way. It can therefore be a preventive measure as well as a restorative measure and as such it is a strengthening feature to the fabric of the entire community.

2. PROFESSIONAL TRAINING

I am the Associate Director of one of the 12 national “mental retardation research centers,” the construction of which was partly funded through part A of Public Law 88-164. Part A expired in 1967, so no new centers are being built now. Our research centers, while they need continued and expanded support, are receiving core funding through the National Institute on Child Health and Human Development with the result that a cohesive and increasingly effective program of research has been mounted.

I foresee that you will become increasingly aware of our scientific impact in the years to come in the South in Peabody and also in Chapel Hill.

I am not an administrator or a staff member of one of the university-affiliated training centers authorized in part B of Public Law 88-164, I am not a member of that group, that would gain support from passage of title II of this bill. Even so, I recognize the need for and urge the support core funding and expanded development of the university-affiliated training facilities.

The training of the variety of professionals required to evaluate and treat the developmentally disabled must proceed and must be extended to regions of the country not yet covered.

The results of the research we are generating in our research center must reach the people who need it. Trained professionals and middle manpower can do that, but not less similar core support is provided for these clinical training programs in the UAF's.

Eventually we can look forward to the linking of the basic and applied research, professional training, and community services envisioned by Public Law 88-164. But this will not be possible without renewed Federal support.

The Developmental Disabilities Act of 1970 would provide the vigor that is needed and mount as significant a service and training program as we have now within our reach in our research centers development.

3. PARTNERSHIP BILL

This is an ecumenical bill—ecumenical in bringing under one umbrella disabled persons with common needs despite their different diagnostic labels. Special interests that, prior to this, have competed for public support are now following the lead of those who have pushed comprehensive planning for the good of the majority. The areas where service delivery and professional training are similar from one kind of

disability to another, can now be combined into a strong program to identify problems early and set up a successful treatment program.

I strongly support this combination of interests for it would provide the most united front we have seen for some time in our efforts to help those in our country who are handicapped by one developmental problem or another. I am indeed disappointed that the administration does not seem to welcome this initiative, but rather is taking the short-sighted view of sticking exclusively to mental retardation.

This developmental disabilities approach seems to me to be entirely consistent with the times.

We need efficient use and deployment of all our resources.

We need to use stringent criteria to evaluate the effectiveness of our programs.

We need to enlist the advice and support of the consumer in the development of service programs.

This bill has all those elements and capabilities. The UAF's are model service delivery systems that train professionals at the same time they serve the regions where they are located. In addition they provide opportunities to test whether our research is effective and relevant. All accomplished at the regional and local level.

In summary, I strongly urge this committee to promote an early passage of H.R. 14237 or S. 2846. It is one of the utmost urgency to do so in order to—

1. Expand and improve services for the broadest spectrum of developmentally disabled children and adults, and their families;

2. Provide a badly needed renewal of service program development, professional training and Federal commitment to solve one of the Nation's leading health and social problems; and

3. Provide an emphasis on local and State activity that will help move the results of research, the products of training and the outcome of comprehensive planning into action against those factors that disable so many of our Nation's children.

That completes my prepared statement, Mr. Chairman. Thank you.

Mr. ROGERS. Thank you very much, Dr. Stedman. Your testimony is most helpful.

Mr. Preyer?

Mr. PREYER. On the next-to-the last page you say:

The UAF's are model service delivery systems that train professionals at the same time they serve the regions where they are located. In addition, they provide opportunities to test whether our research is effective. All accomplished at the regional and local level.

Could you give us a little more specific information on how you do train professionals and serve the regions where they are located?

Mr. STEDMAN. Yes, sir. The best way to train professionals in all disciplines is to train them in a model delivery system. A good clinic or a good demonstration or service program. And, this, in its process of operating serves the members of the community within its reach. This is certainly true in central North Carolina, it is true in the western part of Tennessee, it is true in southeastern Florida, it is true within a general region area where a university affiliated training center is now located.

I think this would be a statement that most of the directors of the UAF's would concur on. The important thing to do now is to realize that by placing substantial core supports within the training facilities and linking them in more than a haphazard way with the producer of research we can then begin to provide not only more manpower in the health and related areas, but we also can provide them with the latest in treatment approaches, if we are sure to link our research activities with our training activities.

At the moment we rely fairly heavily on social and informational linkages because the research program is rather young, it is about 18 months old in terms of its beginning effectiveness. If the UAF program were to decline, then there would be, in my judgment a jam up of the research activities and a failure to deliver them actively to the people who need them.

Mr. PREYER. There are 12 of these centers at the moment?

Mr. STEDMAN. Yes, sir.

Mr. PREYER. And you feel that you are making this link up, that you are getting the benefits of research out into the areas in the form of service?

Mr. STEDMAN. Yes, sir. Of course, my own area is primarily in behavior and social sciences. But the general area of research in developmental disabilities places an extra responsibility on researches in that area, because the kind of things that we come up with, whether it is a new kind of reading program or a new kind of physical therapy or a new kind of screening program, has with it a kind of political valance, if you will, it suggests that somebody stop doing what they are doing and do something else, and start to do something they are not doing. And we have an extra responsibility to show what needs to be done and how to do it. So the information and instruction phase in conjunction with the programs is exceedingly important.

And this can be done if we help to straighten these training programs and continue to support these training centers.

Mr. PREYER. Thank you, Dr. Stedman.

Mr. ROGERS. Dr. Stedman, could you let us have for the record some of the advances made in the treatment and services of the disabled in our research centers? I think it would be well for the committee to have this put into the record, if you would let us have that information.

Mr. STEDMAN. Yes, sir; I would be glad to.

(The material requested was not available to the committee at the time of printing.)

Mr. ROGERS. I think it would be very helpful. And I think many have been made. Can you think of any dramatic ones offhand?

Mr. STEDMAN. Well, the activities of the center, sir, are well documented. And we have access to them of course from NIH. We are moving very rapidly in the area of early identification, not only in the medical field in prenatal diagnosis, but also in the behavior sciences field in recognizing toddlers and preschoolers who have declining developmental curves.

That is very important, because we have to dig many of these kids out of the community and not wait for them to arrive at school. This is a very active area of research.

Another is the training of parents to work with their children. It is exceedingly important that we consider parents and manpower if

our treatment approaches. This has to be well evaluated as to how that can be done, how extensively, what is the most efficient way to do it.

We have to do research on evaluation. What about the cost benefits approach to various treatment programs? This has to be looked at.

There is a broad spectrum of basic to applied research that is very exciting and is going with great gusto.

Mr. ROGERS. We appreciate it.

I think the point you have made that many people do not think about when we talk about the disabled is the family implication that you brought out very well in your testimony. And I think we will cover that in our debate on the floor in trying to impress Members of Congress with the ramifications of this whole problem of retardation.

I do not think this has been duly appreciated.

Mr. STEDMAN. I am glad to help.

Mr. ROGERS. Thank you very much. That has been very helpful.

Our next witness is an old friend of this committee, Mr. Harry Schnibbe, who represents the National Association of State Mental Health Program Directors.

We appreciate your willingness to indulge the committee in its efforts to try to finish with the testimony today so that we can begin a writeup of the bill rapidly because of the time element.

Mr. Schnibbe, we shall be happy to hear from you at this time, sir.

Go right ahead.

STATEMENT OF HARRY SCHNIBBE, EXECUTIVE DIRECTOR, NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS

Mr. SCHNIBBE. Thank you, Mr. Chairman.

We are happy to cooperate with the committee, in every way we can.

Mr. ROGERS. Thank you, Mr. Schnibbe.

If you could have your representatives file their statements tomorrow, that would be fine.

Mr. SCHNIBBE. That is what I was going to suggest, Mr. Chairman.

You understand that I am operating under a handicap. We had planned to have as a witness tomorrow for the States, Leonard Ganer, M.D., Administrator of the Mental Retardation and Mental Health Programs for the State of Wisconsin.

Mr. ROGERS. Yes. We will receive the statements for the record and the committee members will go over them.

Mr. SCHNIBBE. We will probably have Dr. Ganer's statement tomorrow, Mr. Congressman. (See p. 312.)

Mr. ROGERS. That will be fine.

Mr. SCHNIBBE. What I will do on this very short notice is to kind of give you a capsule position of the State program directors, paraphrasing what I think Dr. Ganer might have said.

First of all, as you understand—we have discussed this before, but I will say it again for the record—the State Mental Health Program

Directors administer most of the public institutional and community programs for the mentally retarded in the United States.

There are only 16 States where the mental health director does not have administrative control of the mental retardation program.

The majority of the retarded are under the mental health directors in States like New York, California, Michigan, Missouri, Illinois, and so on.

The position of the State directors is almost totally in support of your bill with some of the amendments that were added in the Senate bill. I have not had time to organize my thoughts to be absolutely precise for you, so I—

Mr. ROGERS. We are used to that approach in the Congress. You can say whatever you feel.

Mr. SCHNIBBE. I may say today that I do not like a certain provision of the Rogers' bill. Whereas our witness tomorrow would have said it a little more tactfully.

Mr. ROGERS. I would still have gotten the point, Mr. Schnibbe.

Mr. SCHNIBBE. You would have gotten the point.

As a general statement on the whole proposition that you are attempting to handle in your bill, I think we would say that the existing programs of the Federal grants to the States for the mentally retarded and others disabled from birth are not getting the job done.

These programs are fragmented, competitive, jerry-built, inflexible, indirect, unplanned, and unrealistic. And they should be wiped out and reassembled into a comprehensive program such as you want to do.

What is needed is a single grant commitment by the Federal Government to each State on a formula basis. Most of our people—I have not polled each one of them, but I have just come in from a meeting of the Western State Mental Health Directors, and I know that that is their feeling—most of them do not favor project grants, they want formula grants to the States.

Mr. ROGERS. Would they have objection to a certain amount of funds, say, a certain percentage allocated maybe for project grants?

Mr. SCHNIBBE. Yes, I think so. I think they would rather see it all formula, no projects at all.

Mr. ROGERS. They would not want any project grants, is that correct?

Mr. SCHNIBBE. I do not think so. There may be one or two States that would argue for some project money. But most of the sentiment that I pick up—for example, at our meeting in San Francisco yesterday—is that this should be a formula grant program. I realize that the Senate has added a project section. And if I remember correctly, that is not in your bill, is it?

But anyway, our feeling is that this can be controlled a lot better if a formula grant is made to the State. I hate to use the word "block grant," it has become sort of a Republican-type phrase, but this is what we are really talking about, a grant to a State with the State having not necessarily the right to administer this, but the responsibility for administering this formula grant, and being held to that responsibility.

I think there would be no objection on the part of the States if it were made clear in the legislation or in the committee report that the congressional intent is that the States have a responsibility—that they be held responsible for the distribution of this money.

In regard controls and reports, I think you probably have them built in well enough in your bill. But we should be sure that those are enforced. I do not think the States have any objection to this. They do not want money that can be just poured into the general treasury and lost.

This should all be accounted for and all in accordance with the proper plans that you have spelled out in your bill.

So we are not claiming this as a right, but really as a responsibility of the State to determine how this money is handled.

I presume that preceding witnesses have talked with you about the types of disability that would be covered, and the type of programs that should be brought together in this comprehensive new program.

I might also add that we feel very strongly—again, I am coming in without knowing what the administration has testified before me because I have been on the west coast—but we feel very strongly that HEW should give the developmental disability services program a very high visibility in the administration. I might add—now I am sticking my neck out a little bit, but I think I can reflect the opinion of the State mental health directors—that there is no feeling among them that all or any of this type of program should wind up back in the mental health area of the HEW program, the National Institute of Mental Health, or any similar health-oriented agency.

I think that almost across the board the sentiment among the State mental health directors is that this belongs in probably SRS, unless there is some way to give it higher visibility than that at the Secretary's level. But presuming it has to stay within SRA, it should be given a good strong visible position in there, because this is putting a lot of programs together, and if you bury it way down the line in some minor administrative structure, this thing will bog down the way the present MR program is bogged down, which is not the fault of any of the MR administrators now in office but rather the fault of whoever buried it within the total structure of HEW.

So we feel strongly that unless HEW comes along and gives this some real attention, your intent here is not going to be achieved.

It is just going to be lost.

I might mention at this point also that of course we do not support for a minute the administration position, which I presume they have made again as they did in the Senate, that the money for this program should be equal to the present construction allotment per state for community MR facilities. This is ludicrous. And we hold no brief for this at all.

We would probably be more inclined to support the funding levels in the Senate bill than in your bill, because they are more generous. However what you can work out between you remains for your good judgment. But we would support substantial sums in the nature of \$100 million, rather than the \$30 million level that the administration is talking about.

Of course, we cannot live with that. The sum they are talking about would reduce programs all along the line. We might as well just leave the MR programs as they are, if we are going to have to take the money that they recommended.

Now, I think we would want to reaffirm what we have said to you before in other hearings, that we feel there should be a permanent com-

mitment of Federal responsibility for the national mental health and mental retardation programs. I know we have some little disagreements on this, on how programs should be extended with permanent Federal support. But the States do not feel any longer, if they ever did feel this way, but there was a kind of general impression that everybody accepted without questioning, that the care of the mentally ill and the mentally retarded is a State responsibility. The Federal Government, it was romantically believed, should not intrude on this. It is sort of like the now-dead fear of Federal domination of education. We do not buy this. And the claim of the State mental health and mental retardation directors, is that the Federal Government has a substantial responsibility to financially support these programs. It should have come in many, many years ago. If it had we probably would not have had the poor programs that we have had to live with for a hundred years under total State funding and State administration.

Even though you put limits in your bill, and there are limits in the other bills, we hope that somewhere along the line somebody in the Congress will say, this is a permanent responsibility, and the Federal Government has to cooperate forever with States on some kind of a formula, matching basis.

Right now the States are carrying virtually all the burden. And this is also true, as you know, in the Community Mental Health Centers Program. Some people are under the impression that this is a Federal program, but the States put a lot more into the Community Mental Health Centers than the Federal Government does. This is true with the mental retardation programs too. And we think it is about time that the Federal Government began to put some money in and put some controls and exact some responsibility from the people at the other end of the line for good programs, institutional, day care, community care, the whole works.

The next thing is, we support the concept of a strong State plan, as you have in your bill, for total services for the developmentally disabled rather than just a construction plan.

I have said that because of the fragmentation in project grants and lack of control and lack of application into areas where the States think the money is most needed, we favor the formula grant approach over project grants. And we object to even 20 percent going into projects.

I think I have covered adequately the matter of funds. We support significant authorizations and appropriations and not the proposal made by the administration.

We also want to request that you put in your bill when you are marking it up in the section where you give certain advantages in grants to poverty areas, we ask you to add the words "disaster areas."

We have had one example right now. A few weeks ago a tornado swept through Lubbock, Tex., you may remember. And that tornado hit the State school for the mentally retarded. It was not severely damaged. There was no loss of life as I recall. But this Lubbock disaster is an example of the sort of thing that happens to us, as it did in Louisiana and Mississippi, from the hurricanes. What we need in those situations is some kind of Federal help. The type that goes into other areas in the community. Usually we cannot get Federal help immediately into an institution.

Take for example the earthquake in Alaska. That earthquake in Alaska wiped out the Mental Retardation Institution in Valdez. So we hope that you will be able to write the word "disasters" into that poverty section.

This program is aimed at the identified persons with developmental disabilities. I know that the administration keeps talking about the need for applying some of this effort or this money into prevention and research. I think we would generally feel that the prevention can be done by health programs and through NIH research programs.

We hope that this program does not get watered down into prevention and research. This is aimed at the persons who are already identified as mentally retarded or mentally disabled.

Now, let us look at your bill.

On page 5 of your bill, H.R. 14237, line 12, paragraph (c) :

During the period for which it is available for the purpose for which allotted shall be available for reallocation.

This is reallocation of funds—

shall be available for reallocation by the Secretary from time to time on such date or dates as he may fix to other States.

This is reallocation of money to other States if one State does not use its funds.

Recently, 3 or 4 weeks ago, our association, the State Mental Health and Mental Retardation Directors, passed a resolution with reference to the big hassle going on concerning the National Institute of Mental Health decentralization of programs. You are familiar with this.

We are for decentralization. We like it. We have always been for this. We have argued all along, with Dr. Yolles and others at NIMH, that HEW should decentralize grant approval to the regional level. We have also insisted that when it gets decentralized, the power to review and approve grants should be in the hands of competent people; namely, the National Institute of Mental Health people at those regional levels.

In making this resolution a couple of weeks ago the members also said—and this would apply to your bill here too—but they are talking at the time of the community mental health centers—they said, that in Federal programs decentralized to the regional level, the money allotted in those States in a particular region should be left within the region. And I think we would ask you to add language of that type if you agree.

On page 5 of your bill, the language now permits money lapsing in the State of Vermont to go to the State of Texas, or if it lapses in Florida it can go to Oregon. What we would prefer is that first refusal on money lapsing in the State of Georgia be available to one of the States in the Florida region, so that that allocation be kept within the region.

We are for decentralization with all of the proper safeguards and exceptions that would guarantee it would be properly administered. It is our experience, working with HEW regional staff, they understand the geography of the area and the problems of the various regions a lot better than Washington people do who sit in that imitation ivory tower, the Barlow Building on Wisconsin Avenue.

Next in your bill, page 12. This is section 14 in regard to State plans. This says:

The portion of the State's allotment for any year which is to be devoted to construction of facilities which portion shall not be more than 50 percent of the State's allotment.

I think we would favor the Senate position which strikes out the 50 percent.

I have talked to our people about this, and I think—I should not say I think, I know that this is our position, that we do not see any reason to put a figure in there. We fear that if the figure stays in, then agencies might be tempted to keep construction at that figure. It might be wiser in some instances for construction to be 10 percent. The money might be more properly used than in construction.

Mr. ROGERS. This simply sets a maximum that it cannot go over?

Mr. SCHNIBBE. That is right.

Mr. ROGERS. It does not say that you cannot have only 10?

Mr. SCHNIBBE. That is right. And in that sense maybe this will be helpful. But we felt that because any figure at all was mentioned there might be a tendency to use that figure. And we were hoping that we would not be caught in the position of—

Mr. ROGERS. I think the idea was that we did not want more than 50 percent going into construction.

Mr. SCHNIBBE. Well, stating it that way, I think we would agree.

Now, on page 13, section 135—this is on approval of projects for construction—

Each project for construction pursuant to State plan shall be submitted to the Secretary through the state agency.

That is good. We favor the program going through the State agency. So I have no quarrel about this. But what we are not sure about is the nonconstruction money. At this point you would have to go into another part of your bill, which is section 137:

Grants to States for planning and services.

And I am not sure in there—you or Mr. Menger would have to tell me—whether or not there is State agency approval required for moneys other than construction, services money under this section.

I am not quite sure how that would work.

Mr. ROGERS. You see, it would have to be under the State plan. In other words, the State would have to plan it and have this all set forth.

Mr. SCHNIBBE. That is understood.

Mr. ROGERS. And if it is in conformance with the State plan it is OK.

Mr. SCHNIBBE. In effect it would be State approval because it is in the State plan.

Mr. ROGERS. That is correct.

Mr. SCHNIBBE. No question on that.

The next one is page 16, paragraph 4:

Adequate funds are not being provided annually for the direct administration of the State plan.

This is when the Secretary can withhold payments. When we discussed this on the west coast yesterday several directors asked me, what did "adequate funds" mean. And I don't know. And I presume none

of us here really knows at this point. But we merely raise the question about what is going to be considered adequate for direct administration of the State plan. Maybe you cannot tighten it up any further than that. But I point out to you that there were some questions raised about what constitutes adequate.

Mr. ROGERS. That is about the same as existing law, as you know.

Mr. SCHNIBBE. Is it? I didn't know that.

Another thing in your bill is on page 18, line 7, paragraph 81:

A grant under this section for any fiscal year to assist the State in meeting the cost of developing and administering its State plan may not exceed 3 percent of the State's allotment.

We are wondering whether or not you want to make that conform to the Community Mental Health Centers Act. It is 5 percent——

Mr. ROGERS. Five or a hundred thousand?

Mr. SCHNIBBE. Yes. We do not have any strong feeling on this except that eventually somebody is going to say, why aren't these the same. And frequently it is the same agency administering it, too.

Mr. ROGERS. Hill-Burton, I think we put four and a hundred thousand.

Mr. SCHNIBBE. Is it?

I do not know whether it makes any sense to make these consistent or not. Some of our people felt that administering this new program is going to be more complex than administering the community mental health centers plan. So they would argue that there is going to be more administration involved here.

Starting on line 15 of your bill on page 18 we would prefer not to have your formula and prefer to have the 80-percent formula in the Senate bill, which is page 20.

I am now working from the Senate bill S. 2846 as reported, not as it was passed by the Senate. So the paragraphing is different in the Senate-passed bill. But this happened to be the one that I had with me on the plane, reading it enroute in here to this hearing.

That section I am talking about in the Senate bill is section 137, paragraph 8, and it says—

The Federal share for any State for purposes of this section for any fiscal year shall be 80 percent of the expenditures other than expenditures for construction.

And so on.

And we would favor this.

Mr. ROGERS. I think that might be a little high forever, 80 percent.

Mr. SCHNIBBE. Nothing is too high forever.

Mr. ROGERS. I think we are coming to, as we discussed when we passed the community mental health bill, that eventually we probably would consider in the next go-around a percentum of support of all the operation of the center, maybe a 40 percent or 45 percent.

Mr. SCHNIBBE. I think this makes sense.

Mr. ROGERS. But I think it is developing. I think 80 is a little much.

Mr. SCHNIBBE. In terms of permanent support 80 would be too much. We do not have to argue about that, because we have been saying to you that there should be a continuing 30 to 40 percent of Federal involvement in mental retardation and mental health programs. And I think we all look toward that eventually, because we all are beginning to see that there has to be Federal involvement in these programs with

proper controls. Then we will be able to avoid the inadequate programs we have had to live with for a hundred years.

In the Senate bill, S. 2846, they have added some sections under section 130, they have added a (c), (d), (e), and (f), all of which we favor.

Again in the Senate bill, 2846, section 134, the Senate has added a paragraph 2 under B, which requires that the State plan:

Describing the quality, extent and scope of services being provided, and to persons with developmental disabilities under such other State plans for federally assisted State programs as may be specified by the Secretary, but in any case including—

And then it lists about 8 or 9 different programs here. And we would like to see that in your bill, we would like to see it in that language, because it spells them out. These are all programs that have to be pulled together at the State level. And happily if they were pulled together at the HEW level it would help, too.

The last item I have here, I think—we have discussed that. That was the 80 percent on which we agreed, but do not agree.

I think, Mr. Chairman, that is all I have to contribute here. We will give you Dr. Ganster's prepared statement. And we appreciate your giving us notice to get in here and get a couple of licks in on this.

Mr. ROGERS. I think this has been very helpful to the committee. And we appreciate your being willing to come in on such short notice.

Mr. Chairman?

Mr. JARMAN. I have no questions.

Mr. ROGERS. Mr. Preyer?

Mr. PREYER. I have no questions.

Mr. SCHNIBBE. Thank you, Mr. Rogers.

(The following statement was received for the record:)

STATEMENT OF LEONARD J. GANSER, M.D.,¹ PRESIDENT, NATIONAL
ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS

REPRESENTING

An Association of State mental health agencies with administrative responsibility for the majority of the mental retardation programs in the country.

164,641 mentally retarded persons annually in the 147 residential facilities administered by these State agencies. In addition, we administer or partially fund hundreds of day care, training, and diagnostic programs in local communities.

There are well over one billion dollars expended by the states in such programs for the mentally retarded and still more by communities.

KEY ISSUES

1. We firmly support the Developmental Disabilities concept.
Service to related problems.
Combinations of these disabilities often exist in the same person.
2. We are convinced that a permanent system of Federal support is necessary.
Essential to consistent progress of high quality services to the mentally retarded.
Programs of prevention, care, and training must be built over a period of time.
3. We strongly support the formula grant idea.
Current mish-mash of schemes, each seeking hard to come by dollars, result in tragic fragmentation and inflexibility of the use of money at the State level.
Purposes of Federal programs may not meet State or local needs at all.

¹ Leonard J. Ganster, M.D., Administrator, Division of Mental Hygiene, Department of Health and Social Services, Madison, Wisconsin.

Competitive nature of funding tends to favor the State or community with more resources already available.

Consolidation of programs and authorizations at the State level effectively increases the payoff from massive State expenditures.

Federal programs have not provided the same stimulation to well-organized State mental retardation programs that they have in some other areas.

4. We support the requirement of a State Plan for services as a most sensible and practical idea.

Federal support then affects all services.

Your leadership would help us develop a comprehensive program for the mentally retarded in the states.

5. It is essential that each state have the responsibility to determine the utilization of Federal support.

The States best know where their priorities are.

The phrase allowing the State to "Review and Comment" is the death knell to ever having consistently-strong State agencies.

More consistent with P.L. 90-577 (the Intergovernmental Cooperation Act of 1968).

Would allow State to use resources to provide technical assistance to communities.

6. Significant authorizations and appropriations are required if the legislation is to have any impact at all.

SPECIFIC COMMENTS ON THE LEGISLATION PROPOSED

1. The legislation should provide for as much flexibility in program as possible. The absence of items specified in Sec. 130 (c), (d), (e), and (f) of S 2846 in HR 14237 tends to place too much emphasis on Sec. 130 (b) specifically relating to construction. Consideration should be given to returning items (c) through (f) to the final Bill.

2. The advisory council of twenty members specified in the Senate version seems too large and the twelve members in the House version somewhat too small. Perhaps an appropriate compromise would be a fifteen-member advisory council.

In either case, it would be important to have a clear statement of the relationship between this advisory council and the President's Committee on Mental Retardation developed.

3. The non-duplication aspects of Sec. 134(2) of S. 2846 seem reasonable and would be useful to make the State Plan more informative concerning how this program relates to other federally-financed programs.

4. In reference to the development and administrative costs, the 80% matching specified in Senate Bill 2846 allows for greatest flexibility. However, if a specific percentage is to be used as in HR 14237, Sec. 137(b) (1), 5% should be used to keep this more consistent with other Federal programs. It should also be made clear that there can be carry over of these funds for one year.

Whichever of the above versions is used, either is far more useful than the 75% provided on a project grant basis as specified in HR 15160.

5. The provisions of HR 14237 for grants for service specify a declining percentage down to zero and limiting the Federal support to salaries seem to place handicaps on the State in effective utilization of the funds.

For instance, if continued support of a program of service in a rural, poor area at a 30% level was very high priority, in the State's judgment such vital continued support could not be provided.

6. It is important that in HR 14237, page 15, lines 4-5, it is stated clearly that construction grants come through the State agency and must be approved and recommended. The same provisions should be clearly stated in reference to the service grants.

7. The effective date for the issuance of regulations by the Secretary in both S 2846 and HR 14237 are much too soon and cannot be accomplished.

8. In reference to the university affiliated facilities, the addition of the priority on participation by Junior Colleges seems to be a very important one. Perhaps this could be broadened to include other types of community colleges in the definition.

GENERAL COMMENTS

1. Even though the programs intended under this legislation are for the already-identified mentally retarded and developmentally disabled and even though

basic prevention programs are the responsibility of other elements of the Department of Health, Education and Welfare, these programs can have a sound preventive effect if the States have sufficient flexibility to put money into early life services leading to very early identification of the potentially disabled.

2. It cannot be overemphasized that the formula grant system makes it possible for the States to carry out their responsibilities more effectively. They can then control the coordination with other health, education, and social service programs. *Under the project grant system, there is essentially no control at all.*

3. There must be high level authorizations and appropriations for the program to have impact. An appropriation which merely takes care of existing obligations is very detrimental since it gives promise of things which cannot be delivered.

Mr. ROGERS. Before we conclude, I understand that the one witness we have remaining will submit his statement for the record, which will be received.

That, then, will conclude our hearings. And we are very grateful to all of you.

The committee stands adjourned.

(The following material was submitted for the record:)

PRESENTATION OF TESTIMONY FROM THE SAN JOAQUIN ASSOCIATION FOR RETARDED CHILDREN, STOCKTON, CALIF., AND THE SAN JOAQUIN COUNTY MENTAL HEALTH SERVICES, ADULT MENTAL RETARDATION CENTER, STOCKTON, CALIF., BY CONGRESSMAN JOHN J. McFALL

Mr. Chairman, It is a privilege to present testimony, in the form of letters, from two of the most active and dedicated organizations in my Congressional District involved in mental retardation programs. They are supporting the proposed Developmental Disabilities Services and Facilities Construction Act of 1970.

Both organizations are in favor of this vital authorizing legislation and have asked me to support it, which I do wholeheartedly.

I know that this Subcommittee will recommend legislation to meet the challenges presented by our many youngsters who are afflicted with this condition. At this time, I would like to enter the two letters in the record.

SAN JOAQUIN COUNTY MENTAL HEALTH SERVICES,
ADULT MENTAL RETARDATION CENTER,
Stockton, Calif., June 23, 1970.

Congressman JOHN McFALL,
House of Representatives,
Washington, D.C.

DEAR MR. McFALL: I am writing with two purposes in mind. First, I would like to thank you for the assistance that you provided in our recent application for a SWEAT (Student Work Experience and Training Program) Grant. We received the Grant and plan to have the first young people join our staff on June 29.

We have recently learned that legislation to provide federal monies for mental retardation facilities is in jeopardy. Of course we are concerned because of our professional interest in the mentally retarded, but we are also specifically concerned because of the impact that this type of legislation has had on the development of our program. We thought it might be of some assistance to you to point out some of the relevant facts with regard to San Joaquin County's Mental Retardation Program.

The San Joaquin Association for Retarded Children built one of their buildings in 1967 with a Hill-Burton Grant under the Mental Retardation Facilities Construction Program. In late 1968 when San Joaquin County assumed the

administration and funding of this program the building constructed by Hill-Burton Funds was and remains the nucleus for our entire program. I question whether San Joaquin County would have been able to handle the capital development of such a facility and without such a building it is questionable whether our program would be as large as it is and serving the number of mental retarded as we now serve.

It seems to me that the most difficult area in programming for any sort of health problem, including mental retardation, is in capital development. Programming itself is difficult enough but when one is faced with building problems in addition, then the difficulties become almost insurmountable.

I hope my comments are of some assistance to you when you consider your position on this Act. We thank you for your interest in the mentally retarded and the assistance you have provided us in the past.

Sincerely yours,

CHARLES M. MOODY, MSW,
Chief Clinical Social Worker.

SAN JOAQUIN ASSOCIATION FOR RETARDED CHILDREN,
Stockton, Calif., June 23, 1970.

Congressman JOHN J. MCFALL,
House of Representatives,
Washington, D.C.

DEAR CONGRESSMAN MCFALL: I am writing on behalf of our Association in regard to the pending Developmental Disabilities Services and Facilities Construction Act. As you know, this Act has had a profound influence on programs for the mentally retarded in San Joaquin County. Our Association was one of the first recipients of a grant to construct day facilities for the mentally retarded. This was in 1967. This initial facility, which serves mentally retarded adults, has grown to the point where it has a budget in excess of \$170,000 per annum and serves more than 100 retarded adults on a daily basis. In addition, it has served as the nucleus for an expanded community mental retardation program. We seriously doubt if this significant impact on retardation in our country would have been possible without the impetus provided by the federal facilities funding.

In addition, San Joaquin County has been the recipient of an additional grant which provides a significant portion of the money for a Development Center for Handicapped Minors.

This is a facility and program serving mentally retarded youngsters from age 3 thru 21. These are the most seriously handicapped of the mentally retarded and this facility is designed to provide these children and their families with an alternative to state hospitalization and to encourage community services. This Center serves children in San Joaquin County as well as adjoining mountain counties and again it is unlikely that the 100 children being served in this facility would have services of any kind if it were not for the assistance provided by the federal government.

We fervently hope that this very critical legislation can be continued and expanded so that areas in our state and country will have the opportunity to develop programs of a similar nature for the mentally retarded. We thank you for the interest that you have continuously shown in the mentally retarded and for your assistance in dealing with this present crisis.

Sincerely,

ROLF R. WILLIAMS, ACSW,
Executive Director.

(Whereupon, at 11:50 a.m. the subcommittee adjourned.)

