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DEPARTMENTS OF LABOR AND HEALTH, EDUCATION, AND WELFARE APPROPRIATIONS FOR 1976

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HEARINGS

BEFORE A

SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS HOUSE OF REPRESENTATIVES

NINETY-FOURTH CONGRESS

FIRST SESSION

SUBCOMMITTEE ON THE DEPARTMENTS OF LABOR AND HEALTH, EDUCATION, AND WELFARE

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PART 1

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Testimony of the Secretary

Special Reports

Printed for the use of the Committee on Appropriations

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DEPARTMENTS OF LABOR AND HEALTH, EDUCATION, AND WELFARE APPROPRIATIONS FOR FISCAL YEAR 1976

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

MONDAY, MARCH 3, 1975.

SECRETARY OF HEALTH, EDUCATION, AND WELFARE

WITNESSES

HON. CASPAR W. WEINBERGER, SECRETARY
JOHN D. YOUNG, ASSISTANT SECRETARY, COMPTROLLER
STEPHEN KURZMAN, ASSISTANT SECRETARY FOR LEGISLATION
CHARLES MILLER, DEPUTY ASSISTANT SECRETARY, COMPTROLLER
WILFORD FORBUSH, DEPUTY ASSISTANT SECREARY, BUDGET

Mr. FLOOD. The committee will come to order.

We now begin hearings on the budget estimates for the Department of Health, Education, and Welfare for fiscal year 1976 and we have the pleasure of having with us the Secretary of Health, Education, and Welfare, Mr. Caspar W. Weinberger.

I think we should have your biographical sketch placed in the record at this point, out of abundance of caution, if nothing else.

Secretary WEINBERGER. All right, sir.

[The biographical sketch follows:]

Caspar W. Weinberger became the Nation's 10th Secretary of Health, Education, and Welfare on February 12, 1973. He was nominated for the post by President Nixon on November 28, 1972, and took the oath of office at San Clemente, Calif., his home State.

He is also responsible for the development, implementation, and coordination of Federal policy in the human resources area.

Secretary Weinberger has served in the Nixon Administration since January 13, 1970, when he became Chairman of the Federal Trade Commission. After 7 months in this assignment, he moved to the newly created Office of Management and Budget as Deputy Director. He assumed the leadership of OMB on June 12, 1972, serving as Director until he was sworn in as HEW Secretary.

Born in San Francisco, August 18, 1917, Secretary Weinberger attended public schools there. He was graduated *magna cum laude* from Harvard College in 1938 where he was elected to Phi Beta Kappa. He received his bachelor of laws degree from Harvard Law School in 1941.

Shortly after his graduation from law school, Secretary Weinberger entered the Army as an infantry private. He served more than 3 years in the Pacific with the 41st Infantry Division and as a member of General Douglas MacArthur's intelligence staff. He was discharged in 1945 as a captain.

Following his wartime service, the Secretary spent 2 years as law clerk to Federal Judge William E. Orr of the U.S. Court of Appeals for the Ninth Circuit. He then entered private practice.

In 1952, while in private law practice, he was elected to the Assembly of the California State Legislature from the Twenty-first District in San Francisco. He won reelection without opposition in 1954 and 1956.

During his years in the California Legislature, Secretary Weinberger was Chairman of both the Assembly Committee on Government Organization and the Joint Assembly-Senate Subcommittee on Alcoholic Beverage Control. His leadership produced a constitutional amendment reorganizing the State's alcoholic beverage control machinery, and the creation of a unified Department of Water Resources.

Newsmen covering the 1955 legislative session in California named the Secretary as the most able member of the State legislature.

From 1959 to 1968, Secretary Weinberger pursued simultaneous careers as a lawyer, writer, and television moderator. He was a partner in the San Francisco law firm of Heller, Ehrman, White, and McAuliffe, and wrote a twice-weekly column on California State Government carried in many State newspapers. He also reviewed books for the San Francisco Chronicle and San Francisco magazine, and moderated a weekly public affairs television show, "Profile: Bay Area," on KQED–TV, the San Francisco educational television station.

Secretary Weinberger headed the Commission on California State Government and Organization—known as the State's "Little Hoover Commission"—from 1967 to 1968. On February 1, 1968, he was named State Director of Finance by Governor Ronald Reagan, serving in the post until he left for Washington to chair the Federal Trade Commission.

Secretary Weinberger is married to the former Jane Dalton. They are the parents of two children, a daughter and a son.

Mr. FLOOD. Do you have anyone with you you would like us to meet?

Secretary WEINBERGER. Yes; I would like to present first of all the assistant secretary for Legislation, Mr. Kurzman; assistant secretary, comptroller, Mr. Young; and his deputy, Mr. Charles Miller.

We have deliberately held the delegation down in response to your suggestion, Mr. Chairman.

GENERAL STATEMENT

Mr. FLOOD. Mr. Secretary, I see you have a prepared statement.

Secretary WEINBERGER. Yes, sir.

Mr. FLOOD. How do you wish to handle this.

Secretary WEINBERGER. Any way that is agreeable to you. I can read it or put it in the record, whichever you perfer.

Mr. FLOOD. It is your show.

Secretary WEINBERGER. I will present it. It is brief. It is a short one and I have a couple of additions that I thought I would make to it and I will include those.

So I will say then, Mr. Chairman, it is always of course a pleasure to have an opportunity to appear before you and to have the opportunity to discuss our programs. We think it is especially important to view our HEW budget as a whole before proceeding to examine its individual parts.

The HEW budget is one part of a comprehensive administration plan to overcome the current economic crisis. In broad outline, this plan proposes a tax reduction to provide an immediate stimulus to the economy and restraint on the growth of Federal spending to keep the deficits caused by the economic slump to a manageable size. Even with the President's proposals to restrain Federal spending, the 1976 deficit will be nearly $52 billion and the deficits over the 2-year period will exceed $86 billion. If Congress does not adopt the President's proposals or does not propose equally stringent alternatives, $20 billion or more could be added to the 1975 and 1976 deficits.

Unfortunately, I think that the Congress has already started on that path because I understand that all of the proposed rescissions af-

fecting our area have been rejected by the committee, so we have begun on a path that could add very substantially to these deficits.

Such a result could push interest rates up again and make it that much more difficult to achieve economic recovery. Even worse, such action would add to inflation, already at totally unacceptable levels. And we should never forget that inflation has its greatest impact on the people we exist to serve—the needy, aged, and handicapped. In 1976 the HEW budget of $118.5 billion in outlays makes up a little more than one-third of the Federal budget, and, of course, makes us far and away the largest of all of the Federal departments and as a matter of fact larger than all but about four or five countries in the world.

Obviously, therefore, our Department must play a significant role in any effort to control the growth of Federal spending. Since this must be done without serious loss to the millions of people served by our programs, we have necessarily faced some extremely difficult choices.

Over the past 5 years, the HEW budget has increased an average of about 15 percent a year. As the President noted in his budget message, Government spending on domestic assistance alone would grow to half the gross national product during the next 20 years if the pattern of the last 20 years continues.

That should be reemphasized, Mr. Chairman. If the Government spending on domestic assistance alone, not defense, on domestic assistance alone, continues at the general pace that it has, the Government spending on that will amount to something like half of the gross national product in the next 20 years.

In 1976, the President's budget proposals would still allow a growth of our budget by 7.7 percent, about one-half the historical growth rate. To accomplish this slowdown in the growth of HEW spending—and that is not a reduction, that is a slowdown in the growth—we have asked Congress to take actions, including both rescissions of appropriations and amendments to substantive law, which would reduce spending by about $8.1 billion.

If Congress takes no action on these proposals—and, as I mentioned a moment ago, you have rejected our requested rescissions, the cumulative 1975–76 deficit would be increased by $8.1 billion and the HEW budget would continue to grow at 15 percent or more, just as a result of a failure of Congress to agree to the President's proposals. If Congress adds new spending, the situation would be worse and the resulting inflation would hurt the needy, aged, and handicapped more than any illusory gain from new or higher spending.

In broad terms, the 1976 HEW budget embodies the following general principles:

> For the noncontrollabe programs we are asking Congress to adopt amendments to the authorizing legislation which would slow down the growth that would otherwise occur. In doing this, we are not proposing any reduction in benefits but are asking that either the increase be reduced or for States to assume a larger share of the financial burden.
>
> For the controllable programs, we are seeking to remain within the revised appropriation request for fiscal year 1975. The 1976

request for these programs is appoximately $350 million lower than the comparable amount proposed for fiscal year 1975.

Nevertheless, within these constraints, we would fund a number of initiatives by proposing offsetting reductions elsewhere within the total for controllable programs.

NONCONTROLLABLE PROGRAMS

These, as I have said take the form of recommended amendments to the basic authorizing legislation and I know these proposals do not come before the Appropriations Committees but I think it is important to mention them here to provide the context in which our budget is being submitted.

The two largest proposals affect social security programs and would limit, for 1 year only, the July automatic cost-of-living benefit to a 5-percent increase and would introduce greater cost sharing into the medicare program. Together these proposals would save about $4.2 billion.

I would note that the President has proposed that all Federal pay and benefit programs linked to the cost of living be limited to a 5-percent increase this year and he is strongly encouraging the private sector to exercise similar restraint on wage and price increases. Nevertheless, total Federal spending for social security cash and medical benefits will increase approximately $7 billion in 1976, assuming that the President's proposals are adopted.

The legislative proposals affecting public assistance include revising the Federal matching formulas in each of the three major public assistance programs: cash assistance, medicaid, and social services. If the Department's recommendations are adopted, the overall average matching rate for these three programs would be approximately 50 percent, although States with low per capita income could still earn up to 78 percent matching under cash assistance and medicaid. We are also putting forward a number of proposals to the authorizing committees, to tighten eligibility standards in order to focus public assistance benefits on those most in need. These efforts would produce outlay savings for both State and Federal Governments.

With regard to the shift to greater reliance on State funding, it should be noted that our proposals would require less than a 1-percent increase in State funding. Further, total Federal aid to State and local governments is expected to reach $55.6 billion in 1976, $3 billion more than in 1975.

CONTROLLABLE PROGRAMS

As I mentioned earlier, the total budget request for HEW's controllable programs is $350 million less than the 1975 revised estimate. Despite this overall reduction, we have been able to fund a number of program initiatives which I would like to call to your attention.

EDUCATION

The Education budget contains $2.3 billion to provide advance funding for the major formula grants for elementary and secondary education.

I am very proud, Mr. Chairman and members of the committee, of this advanced funding concept. That was started in the 1975 supplemental after we asked for it a year before, and that provides school districts for the first time with early and certain knowledge of the amount of Federal assistance so they can plan to use it as efficiently as possible.

As you know, it was necessary to try to fund 2 years' appropriations in one in order to get this cycle started. We are now on that cycle. I very much hope it will not be interrupted because the certainty of the knowledge and the fact that you have that knowledge early from the point of view of the local school districts and the State education departments makes this Federal assistance at least twice as valuable as before. The 1976 advance funding request includes the amounts necessary to trigger the consolidation that was authorized by the Education Amendments of 1974.

Thus, the consolidation of selected elementary and secondary education programs into two broad categories will be implemented during the next fiscal year and continued on this basis in subsequent years.

Besides maintaining formula grant support for handicapped education at the 1975 revised level, the 1976 budget proposes an increase of $26 million in funds for innovative projects to improve the delivery of educational services to handicapped children. In a similar vein, we are proposing new authorizing legislation for vocational education programs which would shift $125 million from the category of general subsidies to school districts for vocational education, to targeted efforts on specific areas of need and innovative educational techniques. This shift will not make a reduction in the total amount of Federal funds being made available to the States but will require more intensive planning and project review before the funds can be spent.

We are again proposing full funding for the basic opportunity grant program of aid to disadvantaged college students. Our budget estimate would provide awards up to $1,400 for 1.3 million full-time and part-time students. An increase of $390 million over the 1975 appropriation is needed to carry out this objective. We are also proposing an increase of $24 million over 1975 for the State student incentive program. This would provide assistance to 175,000 students, 109,000 more than under the current appropriation. We would finance these increases by again asking Congress to provide no funds for supplementary opportunity grants and direct loans—programs which we regard as less effective.

The 1976 budget also provides additional funding for research and innovation, including an additional $21 million to implement the new Special Projects Act, $10 million more for the National Institute of Education, and $8 million for educational statistics.

I believe that the National Institute of Education is now demonstrating that it can program its resources effectively. I would hope, therefore, that the Congress will approve the modest increase in program activity proposed in the 1976 budget. There is also a real need for improved educational statistics. There is a fundamental necessity to expand and standardize educational statistics at all levels, from the local school district on up.

If we improve our understanding of what is actually happening, then I think we can make the most efficient use of our Nation's investment in education, which of course is considerable.

This proposed additional funding is a very tiny amount by comparison to the potential benefits.

HEALTH PROGRAMS

The 1976 budget proposes to implement the new health planning legislation enacted into law last December. We are proposing $75 million in both fiscal years 1975 and 1976 to make the transition to the new health systems agencies and the new State health planning bodies authorized by the act.

The budget for the National Institute of Occupational Safety and Health will permit the annual output of standards criteria on hazardous substances to be raised from 8 in 1974 to 20 per year. New emphasis will be placed on identifying and preventing occupational hazards which can cause cancer. In addition, work will begin on amplifying 375 older standards which have remained unchanged since the Occupational Safety and Health Act was first enacted in 1970.

The budget proposes an accelerated effort to enforce standards for the 17,400 nursing homes which receive reimbursements from medicare and medicaid. To strengthen this vital effort, we consolidated the nursing home inspection force in our regional offices last year. The 1976 budget requests 146 new positions to enforce new regulations governing standards for intermediate care facilities. This increase would bring the total inspection staff to 375.

An increase of $72 million over the 1975 revised budget is proposed for the National Institutes of Health, bringing its total investment in biomedical research to $1.8 billion. This increase would be divided about equally between the National Cancer Institute and other activities of NIH.

The budget proposes an increase of $4 million for the next phase of the new Federal, State, and local health statistics system. The situation here is very similar to that existing in education. Major health financing and resource decisions are necessarily made on the basis of fragmentary or poorly documented statistics. We need uniform data and information on aspects of the health services system which we now know little or nothing about. Again, I believe that the potential benefits of improved statistics far exceed the costs involved.

HUMAN DEVELOPMENT

The 1976 budget provides an increase of $30 million over the 1975 revised budget for the Department's human development programs. For children and youth an increase of $20 million will provide additional services to handicapped children in Head Start, and maintain the momentum and activities of the newly established child abuse programs undertaken in 1975. The 1976 budget will concentrate resources on the severely handicapped in the rehabilitation programs, and provide an additional $6 million for increased training support for students qualified to provide skilled rehabilitation services to the severely handicapped.

I think there is a shortage of people who are trained and equipped to do this kind of service and our request would concentrate on trying to provide additional training support to qualify people in that special field.

PRINCIPAL BUDGET REDUCTIONS

In addition to the proposed termination of two of the less effective student aid programs which I mentioned a moment ago, the direct loans and the supplementary opportunity grant, we are also proposing a number of other funding reductions in the controllable programs. The largest single reduction is our latest proposal to reform the impacted area aid program.

Over the years there has been a growing consensus that this program was inequitable and provided windfall benefits to many of the wealthiest school districts. I think it is of some note, Mr. Chairman, that every single President in recent years, and including all of the ones who have come from the Congress, have changed their minds when they became part of the executive branch and decided that the elimination or major revision of this wholly inequitable, but I suppose politically beguiling, program should be undertaken. It might be tolerable to have a system which provided windfall benefits to the wealthiest school districts, even though it wasn't defensible, when our resources are unlimited.

But under today's circumstances, with a projected minimum deficit of $52 billion, it seems to me that continued large scale funding for impacted aid is simply intolerable, and I certainly hope that this view will be shared by enough Members to bring about the revisions that we have proposed.

I think the growth of impact aid, through the efforts of your committee and the Congress, has been dampened a little, but the total cost still remains very high and we are proposing a new approach in the 1976 budget which would require the school districts to absorb the impact of children of Federal employees up to 5 percent of the school district's prior year operating budget.

The way this would work is that a district's entitlement would be calculated on the basis of the percentages of entitlement in the 1975 Appropriation Act. This would then be reduced by a factor equal to 5 percent of its prior year's operating budget. This would reduce Federal spending by $390 million for that program which, as I said, we regard as quite indefensible.

We are asking States, localities, and private groups to increase their support for health service programs, including maternal and child health clinics, neighborhood health centers, family planning projects, migrant health services, and other special programs directed at disadvantaged groups.

Some have viewed this as an indication of our lack of commitment or support for these programs. It is not that at all. We believe that many of these programs are essential and vital, but we also believe that it is entirely fair, given the existing circumstances, that non-Federal participation be increased to offset the proposed reduction of about 20 percent in Federal grants, and we will be able to maintain the 1975 level of services next year if States and localities believe that

these services are vital for their communities and if they attach the same high priority to these programs that we do. And, I will mention again the increase of about $3 billion in Federal aid to the States and the fact that the increased funding that we are requesting from the States would amount to something less than 1 percent of the total State funding that is involved.

I understand that proposing even modest restraints on growth in any budget is never easy and probably is unprecedented. I know from long experience that it is even harder to get people to agree to these restraints.

But ultimately I think this is the only way to free funds for new program initiatives without ruinous increases in costs, and it is the only way to prevent more ruinous inflation.

I might also add if we don't do it, we perpetuate the funding of programs which we believe have either outlived their usefulness or perhaps were never really effective, anyway.

These are certainly not normal times and I understand that proposals of this kind have been made before in normal times and rather uniformly and automatically rejected, but I hope this year we will be joined by others in recognizing that the times call for nontraditional actions and a special kind of courage.

I invite and urgently need your help, and on a practical note, I think I should add that I really believe this year that your constituents in all parties and in all districts would welcome such evidence of the determination to do something effective about ever higher governmental spending leading inevitably to ever higher governmental taxation.

Thank you, Mr. Chairman.

Mr. FLOOD. Thank you, Mr. Secretary. As usual, you made an excellent statement in the best Weinberger tradition. I can assure you we listened attentively. We read the statement and we will keep your words in mind as we consider the 1976 budget estimate.

EDUCATION BUDGET

This year, as we have on two previous occasions, we intend to act on the appropriations for the education programs separately.

Secretary WEINBERGER. Yes.

Mr. FLOOD. That is, by separate, I mean in a separate education appropriation bill. For that reason, after our overview hearings today and tomorrow with you, Mr. Secretary, and after we complete the hearings on the 1975 supplemental estimates, then we will turn immediately to the 1976 budget estimates for the education programs.

When the education appropriation bill has been reported from committee, we shall resume the hearings on the remainder of the HEW appropriations.

Secretary WEINBERGER. I think that is an excellent procedure, Mr. Chairman, and as I mentioned, I am delighted that we were joined in this idea of advance funding last year and I just hope that cycle can be maintained.

Mr. FLOOD. We did this before on two occasions. We ran into a veto once and we overrode the veto on the separate education bill. We know the need back out in the country, and especially with school districts

and the people who run the schools, to be able to plan their budgets in advance. We have not been able to act separately on education appropriations in recent years because of the expiration of the authorizing legislation. We need laws before we can move, as you know.

Secretary WEINBERGER. Right.

GROWTH OF THE DEPARTMENT

Mr. FLOOD. That is the problem. With regard to your plea for help, Mr. Secretary, I can assure you that, if anybody, this subcommittee recognizes that the direction and management of this conglomerate you have that is known as HEW——

Secretary WEINBERGER. One of our largest growth industries.

Mr. FLOOD [continuing]. Is certainly a superhuman task.

I recall one former Secretary who said that HEW was absolutely unmanageable and it should be broken up. That was 10 years ago. So it was certainly a lot smaller and a lot less complex than it is today.

We would like to help you in every way possible to improve the management and the effectiveness of the HEW programs.

By the way, the committee staff—I am sure your people know that—have been looking into a number of the HEW programs in depth and we will be discussing their findings with your people as these hearings go on.

On the other hand, Mr. Secretary, I am afraid you can't count on us to help you cut back health, education, and the human development programs. We want to improve these programs and make them more effective.

Therefore, we want to be sure that each dollar that we appropriate has its maximum effect. In other words, we want to be sure that these programs are really working and to help you make them work.

Secretary WEINBERGER. We share that feeling completely, Mr. Chairman. We are not asking for anything to be cut back. We are asking to restrain a bit the rate of growth and we are suggesting to you some programs which we believe are not working and what we feel are replacements for them, so I think we are exactly in line with what you have in mind.

"UNCONTROLLABLE" PORTION OF HEW BUDGET

Mr. FLOOD. The total 1976 budget request for the Department of Health, Education, and Welfare is $120.4 billion. Is that correct?

Secretary WEINBERGER. That must be authority. We usually use outlays and we have $118.4 billion in outlays.

Mr. FLOOD. Right. Of that amount, 90 percent—that is $108 billion—is for—and you use and we quote the word—uncontrollables.

Secretary WEINBERGER. Ninety-five percent is the figure we use, which is the outlay comparison.

Mr. FLOOD. Those are activities which are not controlled annually—that is what we mean—through the appropriation bill.

Is that correct?

Secretary WEINBERGER. Well, I guess the simplest way for me to phrase it would be that 95 percent of our budget request represents programs that are uncontrollable in the sense that basic changes in

the structure of the statutes or elimination of the programs would be required before there can be any change in the funding except upward.

Mr. FLOOD. But they are not controlled annually by the appropriation bill.

Secretary WEINBERGER. Well, no.

Mr. FLOOD. Of course, they can be controlled, but not through appropriations.

Mr. MILLER. You do make appropriations, from some of these items, such as public assistance, but you have little choice other than to meet the entitlements.

Mr. FLOOD. These noncontrollable portions of the HEW budget have maintained a pretty steady growth over the last 10 years, haven't they?

Secretary WEINBERGER. Yes, indeed they have, Mr. Chairman.

Mr. FLOOD. Do you have any figures which would illustrate the growth in HEW of the noncontrollable appropriations in recent years and also the growth of the controllable appropriations for the same period of time?

Secretary WEINBERGER. We certainly have that, yes.

Let me just mention one that I happen to have in mind and that is the social security benefits, which is an uncontrollable program, but as I mentioned before, the changes that have been made in that program have all been upward, and in the period of time since roughly 1969 we have had something like a 68-percent increase in the benefits of social security, not because it is indexed or tied to the cost of living; simply because the base has been increased regularly by the Congress.

Against that 68 percent the cost of living has gone up during that same period about 43 percent.

Mr. FLOOD. But you will have figures to show us the growth in the uncontrollables and the controllables during the same period of time?

Secretary WEINBERGER. Yes.

[The information follows:]

HEW OUTLAYS AS NONCONTROLLABLE OR CONTROLLABLE

[In billions of dollars]

	1966	1971	1975	1976
Noncontrollable	25.7	57.6	103.7	112.4
Controllable	2.6	4.3	6.2	6.0
Total, HEW	28.3	61.9	109.9	118.4

CONTINUED HIGH SPENDING

Mr. FLOOD. All those things being so, those figures being there, what would you say are the implications of a set of figures like that?

Secretary WEINBERGER. The implications, I am afraid, are rather clear.

Mr. FLOOD. Not just social security now.

Secretary WEINBERGER. No, no, the whole thing.

If we keep spending on domestic assistance alone, not any defense expenditures or anything of that kind, just on domestic assistance, that spending will increase to about half of the gross national product during the next 20 years if the pattern of the past 20 years continues.

Now, that means at the present time the whole governmental sector of the gross national product is about 35, 36 percent, a little over a third, but if we keep going the way we are just the domestic assistance side alone will be 50 percent of the gross national product in about 20 to 25 years.

Mr. FLOOD. Suppose you let us have for the record a table and in this case the total HEW appropriations for the past 10 years.

Mr. MILLER. Yes, sir.

Mr. FLOOD. When you give us those tables let us have a breakdown of the controllable and the noncontrollable and also, between Federal funds and trust funds.

Secretary WEINBERGER. All right.

[The information follows:]

CONTROLLABILITY OF THE HEW BUDGET

(Dollars in Billions)

	1966		1971		1975		1976	
	BA	Outlays	BA	Outlays	BA	Outlays	BA	Outlays
TOTAL, HEW	$31.0	$28.3	$65.8	$61.9	$114.2	$109.9	$120.4	$118.4
NON-CONTROLLABLES:								
Trust Funds:								
Social Security Benefits	$20.1	20.7	37.9	35.9	65.1	63.5	69.1	70.0
Medicare	.9	.1	8.5	7.9	16.8	13.9	18.6	14.0
Federal Funds:								
Supplemental Security Income	--	--	--	--	4.9	4.7	5.5	5.5
"Black Lung" Benefits	--	--	.3	.3	1.0	1.0	1.0	1.0
Public Assistance	3.6	3.5	9.7	9.6	13.5	13.3	13.4	13.4
Interest Payments, Loan Defaults, Other	.1	.1	.4	.4	.5	.5	.6	.5
Liquidation of Obligated Balances (Controllables)	--	1.3		3.5	--	6.8	--	6.9
Total, Non-Controllable	$24.9	$25.7	$56.8	$57.6	$101.7	$104.0	$108.2	$112.6
% of Total HEW	80%	91%	86%	93%	89%	94%	90%	95%
Controllables:								
Health agencies	$ 2.3	$1.0	$ 3.5	$1.8	$4.3	$2.3	$4.5	$2.3
Education Division	3.3	1.4	4.4	1.8	6.0	2.4	5.5	2.1
Human Development, Other	.5	.2	1.0	.7	2.2	1.5	2.3	1.6
Total, Controllable	$ 6.1	$2.6	$8.9	$4.3	$12.5	$6.2	$12.3	$6.0
% of Total HEW	20%	9%	14%	7%	11%	6%	10%	5%

Secretary WEINBERGER. I do have one that might be of interest and this is in outlays.

In 1966 our outlays were $27 billion, in 1976 $118 billion. That is a decade, and the share of the total HEW budget was 20 percent of the Federal budget in 1966. It is 34 percent this year.

CONTROLLABLE SPENDING

Mr. FLOOD. Your request for controllable programs for 1976 is approximately $350 million lower than the comparable amounts proposed for 1975.

Secretary WEINBERGER. 1975 revised.

Mr. FLOOD. Yes.

We are pretty sure, and so are you, that Congress will not approve the rescissions or the cutbacks in the 1975 appropriations which you have proposed.

Now, if I am right about this, and I have reasonable cause to believe that I am, what is the real reduction in controllable appropriations between 1975 and 1976?

Secretary WEINBERGER. Well, it would be about $1.7 billion.

Mr. FLOOD. Yes, between $1.5 billion and $1.7 billion.

Secretary WEINBERGER. Another way to phrase that is if you don't accept the revisions, the rescissions, and the deferrals that we have requested in the controllable programs, something in the neighborhood of about $1.4 billion would be added by the Congress to the deficits.

Mr. FLOOD. 1.4?

Secretary WEINBERGER. Yes.

PROPOSED REDUCTIONS

Mr. FLOOD. In your statement you mention the proposed spending reductions, $8.1 billion. Can you give us the list of the items that will make up that figure?

Secretary WEINBERGER. Yes; we have that right here. It would be made up of a 5-percent limit on the social security benefits, that I mentioned before, as well as the SSI program. It would be made up of additional medicare cost sharing. It would be made up of certain other basic changes in the social security law. It would be made up of revised matching rates that we have mentioned in the public assistance programs, including social services.

Mr. FLOOD. By matching you mean the States?

Secretary WEINBERGER. Yes, sir.

It would include some other public assistance changes and $700 million of rescissions of the 1975 appropriations and various other items that would total about $500 million for a total of $8.1 billion.

Mr. FLOOD. How much of that $8.1 billion is within the control of this subcommittee of the Appropriations Committee and how much is dependent upon changes in the basic law?

Secretary WEINBERGER. As I mentioned in the statement, the bulk of it is dependent upon changes by the authorizing committees, and we mention them today simply because we believe that this budget is something that has to be viewed against the whole picture. Therefore we go outside the matters that are just in your bill to try to get this picture, the bulk of which would be before other committees.

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STATE AND LOCAL GOVERNMENTS

Mr. FLOOD. You mention in your affirmative statement the matter of State and local governments and one of the underlying assumptions of the 1976 budget is that the States and the local governments would be able to pick up a much larger share of the cost in operating these ongoing programs.

Secretary WEINBERGER. Not a much larger share, Mr. Chairman; a very small increase.

Mr. FLOOD. Say a larger share.

Secretary WEINBERGER. A slightly larger share.

Mr. FLOOD. All right.

In your statement again you said that the cost of your proposals would require less than a 1-percent increase in State funding.

Secretary WEINBERGER. Less than a 1-percent increase in the total State funding that is now going on.

Mr. FLOOD. What does that mean in terms of dollars?

Secretary WEINBERGER. It is about eight-tenths of 1 percent, and I can get the exact amount here that we would require. It would be $1.6 billion spread over 50 States.

Mr. FLOOD. The level of the surplus for State and local governments dropped from $9 billion in 1973 to $1.7 billion in 1974.

By the way, were the States consulted about this business of their ability to pick up these costs?

Secretary WEINBERGER. Well, I don't know what specific consultation was done. It is my understanding that the President's budget people had considered the fact that the State governments were in surplus in June of 1974. While obviously everybody could have been in better financial condition than they are now, you have to look at the relative allocation of the misery, which puts a greater burden on the Federal Government.

Mr. FLOOD. You are talking about a question somebody hasn't asked you yet.

What I asked you was were the States consulted about this?

Secretary WEINBERGER. I have no knowledge, Mr. Chairman.

Mr. FLOOD. That is what I want to know.

In the light of this current slump, how many States, just an estimate—maybe it is more than an estimate—do you estimate can actually pick up this burden now and at the same time still maintain their current program? How many?

Secretary WEINBERGER. Well, the latter clause means that probably fewer could do it than otherwise. If you were going to ask it the way I thought you would, every State would be able to pick up the burden by revising their priorities.

Mr. FLOOD. I didn't ask you.

Secretary WEINBERGER. But how many States could pick it up and still live. We could get an exact estimate based on figures. I am sure well over half.

Mr. FLOOD. That is what we want to know, just exactly that question.

Secretary WEINBERGER. We have one bit that might be useful.

Mr. FLOOD. And still maintain now their current program.

Secretary WEINBERGER. We will certainly furnish that.
[The information follows:]

ABILITY OF STATES TO INCREASE FINANCING OF SELECTED HUMAN RESOURCES PROGRAM

In fiscal year 1973, 44 States had budget surpluses and the aggregate State and local budget surplus was $9.2 billion. In fiscal year 1974, the aggregate surplus had declined to $1.6 billion.[1] However, the large surpluses accumulated during the past several years are expected to evaporate by the end of fiscal year 1975, and the States in the aggregate are projected to have a deficit of approximately $2 billion. Yet—

Federal aid to State and local governments will increase in outlays by $3 billion in fiscal year 1976 over fiscal year 1975.

Federal aid to State and local governments in the past 10 years has increased more than fourfold, from $12.9 billion in fiscal year 1966 to $55.6 in fiscal year 1976.

After the federalization of the supplemental security income program in calendar year 1974, 42 States were able to reduce expenditures for SSI by an average of 55 percent.

The 1975–76 combined Federal deficit is estimated to be $86 billion; and if outlay reduction proposals are not opposed by the Congress, the deficit will exceed $100 billion.

The aggregate State-local deficit for this same period is expected to be approximately $4.4 billion.

Increased State and local expenditures, which would be required to keep Federal programs at current operating levels, would be less than one-half of 1 percent of total estimated State and local expenditures for fiscal year 1976.

We have no specific information at this time as to exactly how many States could, or could not, increase funding in fiscal year 1976 in certain program areas to compensate for decreased Federal funding. Because of the current economic situation, past estimates are not particularly reliable. Clearly, however, all States could pick up funding if they were to make priority decisions, and reduce funding elsewhere, just as the Federal Government is forced to do. If they do not make such priority choices, we suspect 50 to 75 percent of the States could not increase human resource funding, without raising additional revenues from some source. And, indeed, we have information that they are doing just that.

We are currently working with the National Governors' Conference, the Advisory Commission on Intergovernmental Relations, and the National Association of State Budget Directors to get a more definitive fix on particular States' financial capabilities in fiscal year 1976.

PRIORITIES

Secretary WEINBERGER. I suggest to you in all respect, Mr. Chairman, that that isn't a vital part of the equation, because the important part of the equation is not to maintain all of your programs. The vital part of the equation is to maintain those programs that are most useful and necessary and to make a selection in times such as this rather than simply maintaining all.

Mr. FLOOD. What we want to know is what is the answer to the question, "Will they be able to maintain and without reduction in current programs?" I know it is a matter of opinion, it is a matter of degree, but that is the question we want answered.

Secretary WEINBERGER. If they wanted to do it that way it would require about eight-tenths of 1 percent higher expenditures.

Mr. FLOOD. That is what we want to know.

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[1] Note that most States attempt to achieve a balanced budget.

ASSISTANCE TO STATES

Secretary WEINBERGER. We do have to remember, also, that there will be a $3 billion increase in Federal assistance to State and local governments proposed in this budget and that would take it up close to a $56 billion total.

Mr. FLOOD. We also have this in mind.

Now, even without this additional financial burden that you propose in this 1976 budget, some States, and let us come right around here, just across the river, such as Virginia, have already initiated cutbacks in their programs. There have been a lot of big stories in the paper about this recently, big cutbacks in the program now in Virginia in medicaid.

This would indicate to us that the States are not in a position to absorb this cost. Yet these are the assumptions upon which the HEW budget has been built. They are specious. You look at Virginia.

STATE OF VIRGINIA

Secretary WEINBERGER. I would suggest that the assumption that because Virginia decided to make some cutbacks in their medicaid program means that they therefore couldn't afford to pick anything else lacks a certain foundation because it may well be that what they are talking about are the reductions of some of the waste and abuses in the medicaid program which have been widespread.

Mr. FLOOD. But this is exhibit A for Virginia and if that goes down the line even to half the States, you have a strong indication of their inability to pick up this cost.

Secretary WEINBERGER. Not necessarily, Mr. Chairman. You perhaps have an equally strong desire that maybe the States want to remove the waste in medicaid and the abuses and that requires cutting the cost.

Mr. FLOOD. I am sure they do but if you do this with a hatchet and if you do this merely by a stroke of the pencil—and you mentioned this in your affirmative statement; you were concerned about this—if this is a fact and these States cannot carry this burden, then the people you talked about, the poor, the aged—and I think you used the phrase "the people you exist to serve"—are the ones going to be affected.

REDUCTIONS BY STATES

Secretary WEINBERGER. Mr. Chairman, there are ways in which the States can do the same thing that we have had to do. We have not proceeded with an ax or a hatchet. We have tried to make our reductions usually in the rate of growth, not in the programs themselves, but we have tried to make what restraints and what reductions we have proposed with the idea of trying to remove programs which do not directly affect the poor, the handicapped, and the aged. All of the increases in our budget are for those groups and what we suggest is that it would not be all that burdensome on the States and local governments to review all of their spending to see if it is not possible for them to make some savings in some programs to do the same hard job of selection and choice of priorities that we have had to do.

Mr. FLOOD. But you are making the selections. You say, "We will make the reductions for the following nine reasons." You set up the cuts. You set out the nine reasons. In other words, what your budget is saying is simply this: Here it is all wrapped up and delivered. That budget says, all right, Congress, it is up to you to provide for these people because they are not adequately provided for in the 1976 budget, so, Congress, you provide it.

Secretary WEINBERGER. No, sir, it does not say that.

Mr. FLOOD. It doesn't?

Secretary WEINBERGER. No. What it says, Mr. Chairman, is that we have provided a rate of increase for these people which is perhaps somewhat less than the rate of increase in previous years——

Mr. FLOOD. A matter of degree.

Secretary WEINBERGER. No, but that there is an increase provided in most cases, that in some cases someone other than the Federal Government should provide a portion of the increase and that it will require the same kind of selection of priorities, dropping of some things, such as impacted aid, that will free some money to do a better job for many people who most need it. In impacted aid, you have your provisions that safeguard and help the districts that need it most and that is what we are proposing to do—a hard choice in selection rather than funding everything.

Mr. FLOOD. You can make a whipping boy out of impacted area aid and I don't think you will find this committee, as you know very well, would be in disagreement with you on that. That stands out like a sore thumb. You always use impacted area aid as your example. But you and I know that Congress cannot and will not agree to your proposals to cut back impacted area aid, and that is what this 1976 budget does.

NURSING HOMES

Let's get a little more agreeable. Let's talk about nursing homes. Your budget includes additional funds and staff to enforce these nursing home standards.

Secretary WEINBERGER. Right.

Mr. FLOOD. I want to say here that you are taking a step in the right direction there. Can you explain, however, what is HEW's policy, what will HEW policy be in those cases where these deficiencies are found?

Secretary WEINBERGER. I think very simple, Mr. Chairman, and I am glad for the chance to do it. We will be as helpful, as conciliatory, as patient, as we believe we possibly can with those States and those homes where there appears to be a honest bona fide attempt to remove the deficiencies and make the homes safe. When we have tried to do that for a number of months and encounter a situation in which we believe there is not a bona fide attempt being made to correct those deficiencies, we will turn off the Federal matching share of medicare and medicaid to those homes because we think that the safety of the people in them is paramount to any other factor.

Mr. FLOOD. Is there any money in this 1976 budget to assist these nursing homes to comply with the HEW standards?

Secretary WEINBERGER. Yes, there is. We have requested 146 new positions to enforce the new regulations and the way in which we

enforce the regulations is just as I described. It is to go around and say,

You don't have a sprinkler system. A comparable home can get a sprinkler system for roughly x dollars. You don't have wide enough stairs. You don't have enough exits. You have your most immobile patients on the top floor. If you make these changes, some of which you can do, and so on, then we will continue the financing.

Mr. FLOOD. Does the department have any long-range plans to improve these nursing home situations other than simply sending around a lot of inspectors?

Secretary WEINBERGER. Yes.

Mr. FLOOD. I am talking now about construction money, about training, improvement loans—what about that—not just a lot of people knocking on the door.

Secretary WEINBERGER. We have requested that the Hill-Burton funds be made available for the purpose of bringing the nursing homes up to standard and we are hopeful that we will be allowed to do that rather than building more unnecessary new hospitals adding to the bed surplus.

Mr. FLOOD. We understand that. I am not talking about that part of the Hill-Burton.

Mr. YOUNG. Mr. Chairman, Mr. Secretary, under both medicaid and medicare capital improvements can be charged off to depreciation and, therefore, reimbursed under medicaid and medicare. Last year as I recall about a billion dollars was being charged off to medicaid and medicare on what we call depreciation accounting.

Mr. PATTEN. If a fellow bought a Rolls Royce he figures half was for his use and half he wrote off.

Secretary WEINBERGER. Those are the things we are trying to get at.

Mr. FLOOD. Insofar as funds for construction money or money for training or for improvement loans, things like that, this we don't have.

Secretary WEINBERGER. Yes; we do. We just said that first of all we have medicare and medicaid reimbursements for certain depreciation costs. Also, we have asked Hill-Burton to be modified so that we can use that program for construction activities to bring nursing homes up to accreditation and licensure standards.

Mr. FLOOD. I understand that, but the answer to my question was no.

Secretary WEINBERGER. No, sir, it was not.

Mr. FLOOD. That is an exclamation mark, then. How's that? It will look better.

Secretary WEINBERGER. I understood your question to say, do you have anything in your budget to help these homes improve from the point of view of construction and training, and I was trying to explain to you two of the ways in which the answer is "yes," we do have. We have the Hill-Burton request and certain other improvement costs are covered by medicare and medicaid reimbursements.

SUPPORT FOR PREDOCTORAL TRAINING

Mr. FLOOD. About this matter of training programs, we hear a lot—I am sure you do—from the scientific community regarding the need for more funds to train the predoctoral students. We are getting a

lot of that lately. Can you explain the Department's policy on research manpower development? In other words, if we are phasing down this support now for the predoctoral group——

Secretary WEINBERGER. Is this in the health field, Mr. Chairman?

Mr. FLOOD. Yes. What sources of support are available then for these predoctoral students?

Secretary WEINBERGER. You are speaking about a person who is planning to enter the medical profession?

Mr. FLOOD. Where will these students go for assistance?

Secretary WEINBERGER. First of all with respect to the aid to the medical schools themselves, there are capitation grants that help the medical schools operate. As a matter of fact, the Government pays something over half the operating costs of the medical schools in this country right now. With respect to student loans——

Mr. FLOOD. Guaranteed student loan program.

Secretary WEINBERGER. We do have a student loan repayment program for medical students.

Mr. FLOOD. Not medical students. I am talking about predoctoral training for biomedical research. We know about the medic program. We know about the funds that could be made for the capitation programs and so on. You undoubtedly are talking about the guaranteed loan program, I suppose.

Secretary WEINBERGER. I was talking about the various ways in which a student that wants to become a doctor can be assisted.

Mr. FLOOD. That is one of them. Can a predoctoral student of the basic biomedical sciences obtain sufficient support for that kind of program?

Secretary WEINBERGER. I think he can obtain sufficient support. The question is whether he can obtain it from the Federal Government or not.

Mr. FLOOD. I am talking about the Federal Government program.

Secretary WEINBERGER. We have not proposed increases in that program because we think there are higher priorities and that the Federal assistance to those students is not as necessary because the current market factors, so to speak, are such that they can secure assistance.

STUDENT AID AND TRAINING PROGRAMS

Mr. FLOOD. We have a special report on all of the training and student assistance programs supported by HEW, which will be inserted in the record at this point.

[Report follows:]

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Public Health Service

Student Aid and Training Programs

	1976		
	New	Continuing	Total
Health Services Administration			
Health services			
Training grants	---	$15,231,000	$15,231,000
National Institutes of Health			
National Cancer Institute:			
Fellowships	$ 5,198,000	$ 7,797,000	$ 12,995,000
Training grants	---	5,168,000	5,168,000
National Heart and Lung Institute:			
Fellowships	3,000,000	7,415,000	10,415,000
Training grants	---	10,539,000	10,539,000
National Institute of Dental Research			
Fellowships	---	3,200,000	3,200,000
Training grants	---	2,297,000	2,297,000
National Institute of Arthritis, Metabolism, and Digestive Diseases:			
Fellowships	---	4,109,000	4,109,000
Training grants	---	235,000	235,000
National Institute of Neurological Diseases and Stroke:			
Fellowships	900,000	3,200,000	4,100,000
Training grants	---	3,800,000	3,800,000
National Institute of Allergy and Infectious Diseases:			
Fellowships	500,000	3,710,000	4,210,000
Training grants	---	3,724,000	3,724,000
National Institute of General Medical Sciences:			
Fellowships	850,000	4,650,000	5,500,000
Training grants	---	35,351,000	35,351,000
National Institute of Child Health and Human Development:			
Fellowships	---	3,421,000	3,421,000
Training grants	---	6,094,000	6,094,000
National Institute on Aging:			
Fellowships	---	629,000	629,000
Training grants	---	1,133,000	1,133,000
National Eye Institute:			
Fellowships	641,000	2,012,000	2,653,000
Training grants	---	1,994,000	1,994,000

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Student Aid and Training Programs--Continued

Appropriation	1976 New	1976 Continuing	1976 Total
National Institute of Environmental Health Sciences:			
Fellowships	$ ---	$ 292,000	$ 292,000
Training grants	---	1,453,000	1,453,000
Research Resources:			
Fellowships	244,000	90,000	334,000
Training grants	---	---	---
John E. Fogarty International Center for Advanced Study in the Health Sciences:			
Fellowships	1,195,000	---	1,195,000
National Library of Medicine:			
Training grants	---	1,000,000	1,000,000
Total, National Institutes of Health	12,528,000	113,313,000	125,841,000
Alcohol, Drug Abuse, and Mental Health Administration			
Alcohol, drug abuse, and mental health			
Fellowships	1,303,000	4,174,000	5,477,000
Training grants	---	49,881,000	49,881,000
Health Resources Administration			
Health resources			
Fellowships	---	30,000	30,000
Training grants	---	870,000	870,000
Total, Public Health Service	13,831,000	183,499,000	197,330,000
Fellowships	13,831,000	44,729,000	58,560,000
Training grants	---	138,770,000	138,770,000

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Office of Education

Student Aid and Training Grants 1976

	New[1]	Continuing[1]	Total
Education for the Handicapped:			
Special Education and Manpower Development:			
Fellowships	$ 9,673,850	$ 15,955,970	$ 25,629,820
Training grants	4,339,505	5,845,720	10,185,225
Other grants in Aid	2,136,645	1,798,320	3,934,965
Occupational, Vocational, and Adult Education:			
Grants to States for vocational education:			
Work-study	---	---	---
Higher Education:			
Fellowships:			
Fulbright-Hays fellowships	1,000,000	---	1,000,000
NDEA-VI fellowships	2,810,000	---	2,810,000
College teacher fellowships	---	1,000,000	1,000,000
Allen J. Ellender fellowships.	500,000	---	500,000
Training for the disadvantaged	345,000	405,000	750,000
Subtotal-Fellowships	4,665,000	1,405,000	6,070,000
Direct Loans:			
Federal capital contribution	---	---	---
Loans to institutions	---	---	---
Teacher cancellations	---	8,960,000	8,960,000
Loan volume[2]	(53,495,000)	(110,583,000)	(164,078,000)
Subtotal-Direct Loans	---	8,960,000	8,960,000
Subsidized insured loans:			
Interest on insured loans	52,000,000	215,000,000	267,000,000
Death and disability	---	3,000,000	3,000,000
Special allowance	22,000,000	160,000,000	182,000,000
Loan volume subsidized	(1,492,000,000)	(4,608,000,000)	(6,100,000,000)
Total payment	74,000,000	378,000,000	452,000,000
Grants:			
Basic educational opportunity grants[3]	1,050,000,000	---	1,050,000,000
Work-study	83,000,000	167,000,000	250,000,000
Supplemental education opportunity grants	---	---	----
State student incentive grants.	16,750,000	27,250,000	44,000,000
Subtotal - Grants	1.149.750.000	194,250,000	1,344,000,000
Library Resources:			
Librarian training	---	---	---
Education Activities Overseas:			
Fellowships	380,000	---	380,000
Training grants	1,450,000	---	1,450,000

	New[1/]	Continuing[1/]	Total
TOTAL			
Fellowships	14,718,000	17,360,970	32,079,820
Training grants	5,789,505	5,845,720	11,635,225
Loans (not Volume)	74,000,000	386,960,000	460,960,000
Other grants in Aid	1,151,886,645	196,048,320	1,347,934,965
GRAND TOTAL	1,246,395,000	606,215,010	1,852,610,010

1/ The new category represents monies for students or trainees who are/or will be receiving assistance for the first time, and the continuing category represents monies for students or trainees who will be receiving assistance or grant funds for the second or more consecutive year.

2/ Includes appropriation and collections,

3/ At this point, there is no basis on which "new" can be distinguished from "continuing", due to the newness of the program, changes in the yearly payment schedule, changes in the family contribution schedule and changes in the cost of assistance.

LEGISLATIVE PROPOSALS FOR EDUCATION PROGRAMS

Mr. FLOOD. We mentioned earlier that the committee plans a separate appropriation bill for education for fiscal year 1976. When we did try that a couple of years ago, by the way, it worked mighty well, everybody seemed to think, and we had to stop doing it because we ran into these authorization problems, and that of course held up the appropriations for education. For 1976, however, it does not appear that we are going to have authorization problems. However, the budget for vocational education and the impact aid is proposed for transmittal under—again the word "proposed"—proposed legislation.

Have either of these legislative proposals been sent up to Congress?

Secretary WEINBERGER. I don't know if they cleared or not.

Mr. KURZMAN. I believe the impact aid proposals are already transmitted. The vocational education is I think about to be transmitted.

Mr. FLOOD. You think impacted aid is up.

Secretary WEINBERGER. Impact aid, and vocational education probably within a few days.

Mr. FLOOD. Do you people think it would be possible for Congress to act—just stop a minute to think—or do you think it is going to be possible for Congress to pass such controversial legislation, and I mean controversial legislation, before July 1, 1975, before the end of the fiscal year?

Secretary WEINBERGER. Yes, sir. If there is a similar acceptance of the urgency that we feel about it, I think it clearly is possible.

Mr. FLOOD. If you recognize this committee is trying to report out this early education appropriation bill, what would be wrong with our considering now appropriations in vocational education and impact aid under existing legislation?

Secretary WEINBERGER. It would be a perpetuation of what we consider to be an improper allocation of the Nation's resources.

Mr. FLOOD. What would be the trouble with our doing this under existing legislation?

Secretary WEINBERGER. The legislation for impacted aid is specifically authorized. The additional funding of that program could either be under the existing pattern which, as I have said, would perpetuate the inequities and benefit the wealthiest States, or the allocation——

Mr. FLOOD. You are talking about impacted aid. We know about that. What about vocational education?

Secretary WEINBERGER. In vocational education, it is a matter of simply trying to get the States to develop a much broader set of plans and with a much more, I think, effective approach to it than we have at the present time.

NATIONAL INSTITUTE OF EDUCATION

Mr. FLOOD. Here is something we are concerned about. In the 1974 budget, if anybody can remember that far back, for the National Institute of Education, there was $162 million. Then along comes the 1975 budget, $130 million. In each of these years you recall Congress appropriated about half that amount. Now the 1976 budget, $80 million. That is quite a bit less even with the way you fellows figure things, than the previous years, quite a bit less. Does that indicate a

decline in enthusiasm for the education R. & D., generally or is it a concern about the activities of the Institute itself specifically?

Secretary WEINBERGER. No; I think it is a very reluctant acceptance of the fact that we are unable to persuade the Congress that the function is as important as we believe it is.

Mr. FLOOD. Is that all?

Secretary WEINBERGER. That is my interpretation of it; yes, sir. We spent a very large amount of time trying to convince the Congress that the NIE appropriation in the original amount was justified. One of the problems was that the only condition under which we were able to establish the NIE was to takeover ongoing research of somewhat dubious value, in our opinion. We did that, however, because we wanted to establish NIE and get it started, but then in successive years for one reason or another the Congress has felt an increasing reluctance to fund this R. & D. in education. This year we are asking $80 million.

Mr. FLOOD. That is a lot different. You remember all the criticism that came from the Congress, both sides of the aisle, about the program.

Secretary WEINBERGER. Oh, yes.

Mr. FLOOD. So this has nothing to do specifically with the Institute itself?

Secretary WEINBERGER. No, sir. We have no loss of faith in the importance and necessity of the project but we do feel that in view of the very firmly expressed attitudes in some of the committees of the Congress that this is about all that can be obtained this year.

NIE LEGISLATIVE AUTHORIZATION

Mr. FLOOD. The authorization for NIE expires in June of this year, June 1975, but of course all of the education authorizations now are subject to this automatic 1-year extension.

Secretary WEINBERGER. That is correct.

Mr. FLOOD. Is HEW proposing extension legislation, and if so, if you are, do you propose any significant changes in the present law?

Secretary WEINBERGER. We are proposing extension legislation and we do not have significant changes. We will be pretty well worked out of the mandatory research obligations that the National Institute had to take over when it was created and we will be requesting an extension but at this point we don't plan any significant changes.

APPOINTMENT OF NIE DIRECTOR

Mr. FLOOD. By the way, do you have any idea why the President has not appointed a Director of that Institute? It is difficult for any agency, especially one like this, but any agency at all to operate without a Director.

Secretary WEINBERGER. We have an Acting Director but there is a nomination for the permanent Director and it is being subjected to the normal clearance procedures at the moment.

Mr. FLOOD. That is going to be a clean one.

Secretary WEINBERGER. They all are subjected to the same clearance procedures.

SOCIAL SECURITY TRUST FUND

Mr. FLOOD. There is another thing that the news media very certainly brought to our attention, although our mail does and if you are back home you get it as well. We have all read these articles in the newspapers about the financial condition of the social security trust fund. What is your assessment of the condition of the trust fund?

Secretary WEINBERGER. My assessment of it is that it is sound and that it will pay all of the obligations that are required of it by law.

Mr. FLOOD. Do you think it will be necessary to appropriate from the general fund in the very near future?

Secretary WEINBERGER. No; I think it would be unnecessary and very undesirable. I would like to expand on that a bit if I might.

Mr. FLOOD. Let me put it all together.

What change would you personally recommend—that is going pretty far, but what change would you personally recommend in the social security law in order to avoid a catastrophe in the trust fund?

Secretary WEINBERGER. We arent' near nor are we going to have a catastrophe in the trust fund, but what I would recommend would be two or three things. One would be that the Congress this year adopt the President's request that there be a one-time only, 1-year limitation of a 5-percent increase.

Mr. FLOOD. What would that have to do with what I am talking about? I am talking about organic law.

Secretary WEINBERGER. It is very vitally connected with what you are talking about, because the only reason we have had some of the problems which the press has magnified unduly in this field is because the benefit structure has been increased without due regard to the revenue side of the picture over the past few years, and if we can limit this rate of growth, not a cut, but if we limit the rate of growth to 5 percent that will have——

Mr. FLOOD. Limit the rate of growth?

Secretary WEINBERGER. Limit the rate of growth of the benefits.

Mr. FLOOD. Where is the proposal to limit the rate of growth? Is that a proposal?

Secretary WEINBERGER. If the language is confusing to you, Mr. Chairman, just say put a cap on it then. But what the President has proposed is to limit the rate of increase to 5 percent this year.

Mr. FLOOD. You are talking about this year?

Secretary WEINBERGER. I am talking only about this year. We have to start somewhere. We haven't started on it yet. That is why the papers are talking about it.

SOCIAL SECURITY LAW

Mr. FLOOD. What changes would you personally recommend in the social security law to prevent what we understand might happen or is alleged might happen?

Secretary WEINBERGER. The present social security law provides that the benefits shall increase this year at an amount that will be fixed by the cost-of-living increase. What the President is saying is that there would be a limit on the rate of increase to 5 percent for one year only. That is one change.

Mr. FLOOD. One year at a time?

Secretary WEINBERGER. No, just this 1 year.

Mr. FLOOD. You are gun shy on precedents. The most permanent thing around this town is a temporary law, a temporary building, or a temporary job. That is the most permanent thing in Washington.

Secretary WEINBERGER. I would be pretty surprised if the Congress did pass this 5-percent limitation if they insisted on making it continue beyond 1 year because the President has not asked for that. The next change I would make, and we will have a detailed proposal about this shortly to the authorizing committee, would be that there should be some kind of basic increase in the payroll tax starting around 1979 or 1980. If that is done and if the basic cost-of-living provision that is now in the statute remains, we will be straightened out to where the reserves will cover by more than a year the amount of outgo required.

Mr. FLOOD. I don't want to take all afternoon, though I would like to, but on that last question we would be interested in having from you any recommendations or suggestions or proposals of change in the basic law as it relates to the social security trust funds.

Secretary WEINBERGER. That plus what is usually referred to as decoupling would be the changes that I would propose and if you like we will put them in somewhat more formal form.

Mr. FLOOD. Do that.

[The information follows:]

LEGISLATIVE PROPOSALS FOR SSA TRUST FUNDS

There are three areas where changes can and should be made in order to provide sufficient income to the social security program to meet benefit obligations as they fall due.

The first involves a basic change in the social security cash benefit structure in order to stabilize replacement rates—benefits as a percent of preretirement earnings. Under present law, benefits for future retirees are coupled with both price and wage increases. As a result, under any prudent assumptions about future price and wage increases, benefit levels will rise faster than wages. Such an undesirable and unanticipated turn would add significantly to the long-range cost of the program. The 1975 Advisory Council on Social Security has recommended, and we have endorsed in principle, a proposal that would relate a worker's benefit at retirement directly to changes in wages during his working career while continuing to adjust his benefits to prices during his retirement years.

The second change would be to limit, as recommended by President Ford, the benefit increase payable in the July 1975 to 5 percent rather than to base that benefit increase on the full rise in the cost of living since the last benefit increase. This proposal would limit the rate of growth in benefit expenditures for fiscal 1975; in future years, benefits would be adjusted automatically as the cost of living increases. This one-time cap on the size of the benefit increase, as well as other proposals in the President's budget that affect social security cash benefits and the medicare program, can contribute significantly to any effort designed to assure the financial integrity of the social security cash benefits program over the near term.

The third change would be to provide by the end of the 1970's additional income to the program by increasing social security contributions. The size of this increase would depend significantly on whether or not the proposals recommended by President Ford are enacted by the Congress. If the Congress should fail to enact these proposals, then the increases in social security taxes would be larger than would otherwise be necessary. Under any foreseeable circumstances, though, additional financing will be needed by the end of the decade.

A final point is that we are opposed to proposals that would change the traditional contributory approach to social security financing by injecting general funding into the system.

Secretary WEINBERGER. But it should not be considered, Mr. Chairman, as a formal legislative proposal of the administration.

Mr. FLOOD. I just made that very clear.

Secretary WEINBERGER. Because we still have some staff work to do on it but this is the outline and that is all I would like to emphasize.

Mr. FLOOD. Capital Y-O-U.

Secretary WEINBERGER. But I would also urgently recommend that we not dip into the general fund or take any measures of the kinds that have been discussed rather loosely by some, for meeting what is incorrectly referred to as some kind of crisis or catastrophe.

There is nothing remotely resembling that. In the first place, the Government will meet all of its obligations and is fully able to do so, but in the second place it is necessary to get a sounder basis for funding the trust fund with the enormous benefit increases that have been built in over the last 6 years.

VACANCIES IN HEW POSITIONS

Mr. FLOOD. As I indicated to you a little earlier, let me assure you the subcommittee here is concerned about, as you are, the efficient and effective management of the HEW programs. Yet we cannot see—we have noticed that now for months—how this could be done with all of these vacancies in these very important positions in your setup.

We have been here now for the last several years. They sit where you sit. Why is it that all of these many witnesses in these top jobs appear before us and they are acting this, "acting" in front of their titles, and the Under Secretary's job is vacant, the Assistant Secretary for Health vacant, the Director of NIH vacant, and the Director of NIE vacant, the Director of the Alcohol, Drug Abuse, and Mental Health Administration.

Do you have anything to do with that? I am not trying to put the finger on you now, but I have to ask somebody and there you are.

Secretary WEINBERGER I am affected by it, Mr. Chairman.

Mr. FLOOD. I know you are.

Secretary WEINBERGER. You mentioned five positions. Three out of those appointments have been made and are in the process of having security clearance checks, which is the equivalent of what the airlines would call the final boarding process. Two of the others that you mentioned have acting officers occupying those positions and doing very well. While I think it is completely correct to say that we will do better when we have the permanent appointments made, we are not suffering unduly because of this. We understand the problems that are caused by having vacancies and we are doing everything we can to overcome them.

VACANCIES ON NIH ADVISORY COUNCILS

Mr. FLOOD. Mr. Secretary, on June 24, 1974, when this committee filed its report on the 1975 appropriation bill on page 23 thereof we said, "The committee is concerned about reports of delays in filling vacancies on NIH advisory councils and committees."

Then I have this language: "the committee urges the Secretary to look into this matter and to take whatever corrective action is necessary."

Vacancies in the NIH advisory councils—we understand there were 75 vacancies on NIH advisory councils as of January 1 of this year and, of course, these advisory councils obviously serve a very, very important purpose. Why haven't you filled these?

Secretary WEINBERGER. That isn't really an unduly serious problem, Mr. Chairman. We have something in the neighborhood of 302 advisory committees in the Department. If you have 75 vacancies that means that probably a third of the committees have one or two vacancies which means the committee is functioning fully and probably the vacancies are due to resignations. Sometimes a delay in filling these vacancies is because we have not had an opportunity to secure the kind of balance for the whole committee that the Congress is very anxious to have. That is to say, representation of various groups within the community or various types of specialties within the expertise of that particular committee's ambit.

However, I don't think that is a particularly large number of vacancies, but we have in place a procedure for looking back through our files for requested appointments and recommended appointments when there is a vacancy.

We try to make sure that there are proper representations of all of the various groups that are supposed to be represented and it takes a little time, but I think at almost any given point there is probably at least 50 to 75, sometimes 100, vacancies in this whole structure of advisory committees.

There are a large number of them, Mr. Chairman. Some of them are useful.

Mr. FLOOD. We have heard your predecessors, and you, and your aides come up here and practically break down and cry about the importance of these advisory committees, the greatest thing since canned beer.

Secretary WEINBERGER. That is neither a simile nor a point I have ever made before this committee. I have personally taken actions which have reduced the number of advisory committees by almost 70 in the 2 years I have been there. We are still counting.

Mr. FLOOD. That makes sense and we told you we agreed with you when you started.

Secretary WEINBERGER. That is right. There are some vacancies in the existing ones but, as I say, I don't think that is what I would consider as critical a matter as the earlier vacancies you identified, and part of the problem for those earlier vacancies that you mentioned is the governmentwide problem and that is the fact that the executive level pay schedule has not been changed in 6 years and there are some very substantial recruiting problems as a result of that. This is not the whole picture by any means, but it is one of the factors we do run into.

Mr. YOUNG. Eight of these committees were established by law during the last year, so you are going to get some vacancies on those new committees.

Mr. FLOOD. I think the ones I was talking about were just NIH, which have been in existence for a long time.

Mr. YOUNG. There are 154 NIH committees, including the councils.

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CONTROL OF FEDERAL SPENDING

Mr. FLOOD. Mr. Michel.

Mr. MICHEL. Thank you, Mr. Chairman.

Mr. Secretary, as you know, we share similar views as to the need, in the face of a $52 billion budget deficit, to limit Federal expenditures to the greatest extent possible. In this regard I think you are to be commended for attempting to do so in what is probably the most difficult to control of all departmental budgets. I regret to say that this subcommittee has not succeeded very well so far this year in keeping its spending impulses under control, but I remain hopeful that. while we may undertake individual changes, our final product will in fact fall within the overall $118.5 billion framework you have developed.

When a budget increases as fast as this one has over the past several years—a doubling in 5 years, a quadrupling in the last 10 years—I think we need to pause a little to take stock of where we are headed and what we have accomplished. More often than not, we consider any expenditures with the word "education" or "health" as being sacrosanct and above question. Yet I think we owe it to the taxpayers to assure that they receive top return from their dollars invested. In this regard, one of the things I will be seeking to ascertain this year as we review HEW programs, is what have they accomplished and have the many billions we have spent succeeded in improving the health and well-being of our country. Along this line, Mr. Secretary, I wonder if you or your colleagues have undertaken any analysis as to whether or to what extent the health of our Nation has improved as a result of the tenfold increase in Federal expenditures for health over the past decade.

BENEFITS FROM HEALTH EXPENDITURES

Secretary WEINBERGER. I don't know that you can in any sense tie together the Federal expenditures and the change in the Nation's health. There has certainly been an improvement in the Nation's health. The mortality rate, which is one of the ways in which these things is measured, has been reduced. Life has been lengthened, the average life, by 3 years in the last decade. Infant mortality has declined and there have been a number of other very hopeful indications. There have been many fine research results, including a number of new drugs of great potential benefit. Also in the past few years a tremendous amount of basic research has been funded. However, it is the nature of basic research that it takes some time before you know what your money has bought. These are some of the things that have been accomplished, but I can't say with any degree of certainty that the amounts of Federal dollars are directly related to these efforts. We have had a substantial investment of private funds in the health of the Nation during this same period of time.

Mr. MICHEL. Do we have any available figures showing that latter?

Secretary WEINBERGER. Yes, we have figures showing the change in total expenditures for health. It has just crossed the $100 billion mark and the Federal Government's portion is now about $40 billion, following a very substantial increase over the past decade.

Unfortunately, a large part of that increase is due to inflation. Health care simply costs more, yet we aren't getting a great deal more in net health dollars or health expenditures. In short, we are spending a lot more because the cost of health care has gone up so dramatically.

BENEFITS FROM EDUCATION EXPENDITURES

Mr. MICHEL. Then there are our Nation's children. We have had a threefold increase in Federal education expenditures in the last 10 years. I wonder sometimes, are they better educated today? I read or heard the other day that over here in Maryland or Virginia, half of the persons applying for teaching jobs couldn't pass the grammar test.

Secretary WEINBERGER. I am not surprised really at that and I know that we have had a great deal of difficulty in showing anything in the nature of improvement of reading skills or other basic skills and we have had rather significant opposition from some of the professional education associations for anything like comparative grading or attempts to measure improvements in school systems by examining the grades made by children in the various schools.

SPENDING FOR SPECIAL GROUPS

Mr. MICHEL. There have been direct observations that your budget places a disproportionate burden on the poor and the aged and minority groups in cutting back on Federal spending. I have to field this criticism from time to time. Could you give me some arguments?

Secretary WEINBERGER. In the first place, we believe, as I mentioned before, that excess spending, governmental spending of all kinds, simply fuels inflation, and inflation and large deficits certainly hurt the poor and the aged a lot more than any other groups in the community.

The best analysis that we have put together shows that we will be expending about $500 million more in funds targeted toward the poor, aged, and minorities. This increase does not include the Social Security Trust Funds. In addition, practically all of the $8.5 billion increase that we have asked for in our budget is targeted toward the aged and the poor and the ill. We feel that we are targeting a very substantial amount of our request on the poor and the aged and this runs through the whole gamut of HEW programs, including health, education, human development, public assistance, work incentives, and supplemental security income programs. I think it is not fair in any sense, nor correct, to say that because we have expressed a concern about the size of the deficit and the effect of Federal spending on inflation, we have in any sense proposed programs that will hurt the poor, aged, or minorities.

We certainly do feel that there cannot be the kind of increases that we have had before. Our budget, for example, has increased 15 to 20 percent from time to time in previous years. This year we are requesting only a 7½ percent increase, but it is an increase and almost all of it is targeted toward the groups that you mentioned.

STATE AND LOCAL GOVERNMENTS

Mr. MICHEL. One of the principal policies reflected in your budget is seeking to get the State and local governments to assume a larger

share of the financial responsibility for these programs. Yet we all know, as the chairman pointed out to you, that States and local communities have their problems, too, with growing pressure upon them—although I have often cited their better financial condition in the aggregate than the Federal Government and the fact that in the last several years, through general revenue sharing, we have pumped better than $5 billion a year into the State and local communities. Do you think really your proposals here are realistic?

Secretary WEINBERGER. Oh, yes, sir.

Mr. MICHEL. And attainable?

Secretary WEINBERGER. I think they are entirely realistic. There is no question that there will be objections from States, other governmental units, bureaucracies, and individuals when a slight change is proposed in the existing system, which we have done by requesting a little larger share of funding from someone else. However, there is no need for the States to make any reduction in the services that are covered by these programs. We have picked up for one thing the whole SSI program, covering most of the aged, blind, and disabled expenditures that had been made by the States and local governments. Except to the extent that States wish to supplement it the SSI program is now paid entirely out of Federal funds. We have paid out close to $6 billion in general revenue sharing. In addition we have a situation in which the State and local governments were actually in surplus, on the whole, in July of last year and while no one is, as I said, in a completely healthy financial situation at this time, the relative position of the States and local governments is still better than that of the Federal Government.

We have a situation now in which we are asking simply that less than 1 percent, a little over half of 1 percent of the total States' spending, be used for the purpose of picking up a slightly larger proportion of some of these Federal programs, and when you spread that over 50 States and look at their fiscal position compared with the Federal Government's and look at the effect of our deficit on the economy as a whole, it seems to me it is not only a realistic proposal but also a very desirable one. The key to the whole thing is the point that I was discussing with the chairman a moment ago and that is this, that the States have to maintain or feel they have to maintain everything that they are now doing at the same or at an increased level. However, we are not taking that position with respect to the Federal program. Here we are trying to emphasize those programs which will be most helpful to the poor, and the handicapped, the ill, and the aged.

PROGRAM PRIORITIES

What I'm saying is that we feel we must drop some things to free the funding for other higher priorities, and I believe the States should exercise this kind of priority search. Some States are, in fact, doing this now.

FOOD STAMPS

Mr. MICHEL. Would you like to have the food stamp program transferred to HEW?

Secretary WEINBERGER. No, sir.

LIMITATION ON SOCIAL SECURITY BENEFIT INCREASE

Mr. MICHEL. Following up on the chairman's question with respect to social security, you know there has been a great deal of negative reaction to this proposal that the increase for this coming June or July be limited to 5 percent.

I am reminded of how rankled I was in my earlier years here in the Congress to find those increases voted by Congress becoming nothing more than political footballs every year or every 2 years, to see who could outdo one or the other. But Jack Betts, Mel Laird, and I introduced one of the very first bills designed to tie the social security benefits to the cost-of-living index. I think that was a good and sound principle.

Isn't the thing that gets lost in this whole computation, Mr. Secretary, the fact that in this year if it would be possible to cut the increase from 8 percent plus, whatever it might be, down to 5 percent, and if our base figure is $100 today and we provide $105 instead of $108, that every succeeding year as we build in this building block game by percentages, there is a pyramiding effect that just gets completely out of hand in the end. If you can make that little bit of reduction this year, then next year 10 percent of $105 rather than $108 is something less and similarly every succeeding year.

I recently was advised by the Legislative Research Service of the Library of Congress that a person who retired on January 1 and had been paying into the social security program at the maximum rate since the inception of the program would have paid a total of about $5,000, which would be about the level of benefits he received in just 1 year. Is this an accurate figure to the best of your knowledge?

Secretary WEINBERGER. I would have to verify——

Mr. MICHEL. It may very well be a little bit extreme.

Secretary WEINBERGER. Probably a little bit.

Mr. MICHEL. It doesn't take into account those deductions that could have been invested in interest, and so forth, but there are some striking examples that can be shown that really stagger the imagination, especially if you look down the road here 25 years to the year 2000 with no change in the direction we are going. I think I have used the figure that today you have 30 people on retirement benefits for every 100 workers. By the year 2000, with no change in present trends, you are going to have 50 people retired and on pensions for every 100 workers.

Secretary WEINBERGER. I think that is clearly right and as things are going average benefits will be in the five figures in the year 2005 or 2007. The benefit increases have gone up 68 percent since 1969 and the President is recommending another 5 percent which would be 73 percent.

Mr. MICHEL. In that same comparable period of time now——

Secretary WEINBERGER. The cost of living has gone up 43 percent, so they have out-raised that and, as you said, they have come along with great regularity although they have been quite uneven, sometimes 20 percent, sometimes 13 percent, sometimes 11, sometimes 18, and the simple fact is that what the President is proposing would mean that all the benefits would go up.

They would go up 5 percent, instead of going up the next additional 2 or 2.2 percent. The effect of this would mean that for the average monthly benefit of a retired or disabled worker there would be a monthly difference of $7. If this request is agreed to by the Congress, the Federal Government would save $2.6 billion, which would certainly be a start and expression of some restraint in the growth, not a cut, but some restraint in the growth.

The chairman correctly identified some problems that the social security system will have in the future if we don't give some attention to the gap that has grown up and is widening between resources and expenditures and a lot of people have incorrectly taken sort of a scare headline approach to this and caused a lot of unjustified weakening of confidence in the social security system, but we can't keep increasing the benefits without some indication and some recognition that they are connected with the resources, and to talk about general fund financing of the social security system is totally and completely irresponsible in view of the size of the deficit that already exists in the general fund.

PUBLIC ASSISTANCE

Mr. MICHEL. Moving to the public assistance field, your budget indicates that the figures used reflect legislative changes you are asking Congress to adopt. These changes are designed to save $340 million in fiscal year 1975 and $1.7 billion in fiscal year 1976. If Congress does not adopt these changes then, public assistance costs would amount to about $2 billion more over the next 16 months. Is that correct?

Secretary WEINBERGER. I believe that is correct. However, it should be mentioned that the appropriation request pending before your committee is based on existing law which means that the appropriation can be reduced once Congress passes the proposed changes.

Mr. MICHEL. Assuming Congress does not act prior to the end of the current fiscal year, will you be coming back to us with a supplemental request of an additional $340 million over and above the amount you have already requested in supplemental funds?

Secretary WEINBERGER. No; the same thing is true here as in your earlier question, the supplemental is based on existing law. The funds would be there if Congress does not enact our proposals in time this year.

Mr. MICHEL. The budget cites a number of administrative changes you have taken and are taking to reduce public assistance expenditures. Can you provide us with a figure as to what the total savings in the fiscal year 1976 program will amount to from these administrative changes?

Secretary WEINBERGER. We expect to save about $195 million in fiscal year 1976 through such actions as a tighter review of hospital admissions and length of stay to reduce overutilization and to tighten up the definition of AFDC eligibility by reason of incapacity.

Mr. MICHEL. Have all your proposals for legislative changes been submitted to Congress, or are some or all still being worked on?

Secretary WEINBERGER. Yes; the public assistance legislation has been drafted and sent to you.

Mr. MICHEL. I note that the Budget predicts an increased number of AFDC recipients in fiscal year 1976, from 10,995 to 11,241, but provides for a reduction in the dollar amount of the program, from $4,208,000 to $4,084,000. I assume this reflects your proposed adminis-

trative and legislative changes, but would you indicate for us how this dollar reduction, in the face of increased recipients, would come about?

Secretary WEINBERGER. This is principally because the proposals are generally not designed to eliminate recipients but to eliminate overpayments and other abuses in the system. We are also proposing to standardize the Federal matching formula by eliminating one of the two options—this does not affect the number of recipients eligible for payments.

WIN PROGRAM

Mr. MICHEL. The budget indicates that funds for the WIN program "reflect special emphasis being given to direct placement of AFDC recipients in jobs." Does this indicate that you are deemphasizing training, and are concentrating more on matching participants with jobs requiring skills they already have?

Secretary WEINBERGER. Yes; that is basically the case.

Mr. MICHEL. Does this indicate a view on your part that the WIN program in its training emphasis, has been less than effective in accomplishing the intended objective of moving AFDC recipients from the welfare rolls and into jobs?

Secretary WEINBERGER. The WIN program has not been as effective as we thought it could be in placing WIN-training welfare recipients into long term jobs that pay enough to keep them off welfare; we have concluded that the emphasis of this program should be changed from institutionalized training to direct placement with necessary supportive services such as child care. The latter activity is obviously much cheaper enabling us to serve more clients in what we think will be a more effective manner.

IMPROVED ADMINISTRATION

Mr. MICHEL. You are currently seeking to induce the States to tighten up their administration of the various public assistance programs. Yet I recall in previous years, when States such as California and New York sought to tighten up they ran into a number of obstacles from HEW.

Can we assume now that the policy or attitude has changed; that HEW is now fully cooperating with the States?

Secretary WEINBERGER. As a matter of fact, very well. Those days are long gone, Mr. Michel. We are definitely cooperating with the States in their efforts to eliminate the abuses in these programs because neither of us can find any justification for paying out public money to people who are not eligible to receive it.

Mr. MICHEL. Do we have any legislative proposals in this area?

Secretary WEINBERGER. We are proposing two major legislative changes which would provide for altering the accounting and redetermination periods, requiring a more frequent examination of eligibility; and a change in computation provisions for income disregard. Both of these will go to the authorizing committees.

EXCESSIVE COMPLEXITY OF REGULATIONS

Mr. MICHEL. Moving in another direction, Mr. Secretary, as we have passed new programs in Congress, there is of course a corresponding

need for the executive branch to prescribe regulations and guidelines for the administration of the programs. It is my impression, however, from having dealt with many of those affected by the programs, that the agencies, in their zeal to cover every possible contingency, more often than not go overboard in developing regulations that are excessively complex and detailed, and seem almost designed to make life more difficult for people at whom the programs are directed. Does this concern you, Mr. Secretary, and have you taken any steps within your Department to rectify it?

Secretary WEINBERGER. The more serious problem we have had with regulations has been our inability to get them issued in a timely fashion and we have taken several steps to improve the process as well as to make sure that they cover the essential points without being overly complex or create problems in carrying them out. But I also, agree with you that we should take further steps to make our regulations much cleaner.

REGULATIONS FOR INTERMEDIATE CARE SERVICES

Mr. MICHEL. As an example, Mr. Secretary, of the type of thing I was referring to, my State of Illinois has run into obstacles regarding the new HEW regulations governing "intermediate care services" under medicaid, in which the right hand apparently doesn't know what the left hand is doing. You may be familiar with the sheltered-care facilities in Illinois and perhaps a number of other States which provide supervisory and social services for individuals who are unable to be totally independent but who do not require continuous medical attention. HEW personnel have indicated to the State that persons in such institutions could continue to qualify for medicaid only if the facilities are brought up to the new standards for immediate care facilities, which means providing special nursing personnel and meeting certain special construction requirements, et cetera. Such level of care is not needed for these persons and would cost the State and the Federal Government an additional $12 million each than would be the case if sheltered care were continued.

To retain these sheltered-care facilities, and thus avoid unnecessary increases in expenditures, the State proposes to replace lost medicaid payment with a State supplemental of SSI grants. Yet another arm of HEW then comes along and says this is not possible because any expenditures above "room and board" are health related and should be covered under medicaid. In other words, one HEW agency says the current facilities are not sufficiently health related for medicaid purposes and another says they are, with the State and the beneficiaries being caught in the middle.

I do not propose to take up any more time here with this specific case, but I did want to call the situation to your attention. I have some additional materials, including a good summary memo, which I will leave with you in the hope that you will review the situation and take steps which will hopefully resolve the problem not only for Illinois but for other States in a similar situation.

Secretary WEINBERGER. I am afraid that I do not know enough of the details to answer that here and I would like to respond for the record.

The information follows:

Payments under supplemental security income (SSI) are intended to cover basic living expenses only—for example, room and board. States may provide supplements but if any part of the supplemental is intended to finance health-related services that are or could be covered by title XIX of the Social Security Act (medicaid), then the law requires a dollar for dollar reduction in the Federal SSI payment by the amount of the health-related supplemental.

The purpose of the law was to prevent the financing of health services facilities that do not meet appropriate health and safety standards. The position of the Department and the intent of the law is that facilities providing health services must meet the standards established in the medical program in order to receive Federal financing. However, even if a facility is not certified the resident may still, of course, use his own medicaid eligibility to seek health-related services outside of the facility.

JOINT FUNDING

Mr. MICHEL. One possible approach to rectify situations such as this might be along the lines of an experimental project you are now conducting with the University of Chicago School of Social Service Administration, whereby one agency within HEW is responsible for pulling together all the separate grants to the institution (in this case, 14 different grants) and making one overall grant. I have a letter from the Dean of the school relating his enthusiastic approval of the approach which I would like to be made part of the hearing record. This experiment appears to be right down the same line Congress had in mind when we passed the Joint Funding Simplification Act late last year. Do you have plans to continue and expand this experimental approach as part of the implementations of this act, and are you moving ahead with such implementations?

Secretary WEINBERGER. Yes; I am familiar with the project which was set up several years ago.

I understand that GSA will be assigned responsibility to administer the new joint-funding act and that they are in the process of developing regulations. As far as HEW is concerned, however, the new act doesn't really provide much in the way of new authority to do joint funding which for this Department has been somewhat limited because most of our direct service activities are in State formula grants. To really move ahead with the concept of joint funding requires certain changes in law not covered by the joint-funding act. Our proposed allied services legislation would be a major step forward toward achieving this on a broader scale.

REDUCTION IN HEW PUBLICATIONS

Mr. MICHEL. As I recall it, about a year or two ago, Mr. Secretary, you announced an effort in your Department to reduce the number of publications as well as their often elaborate nature. Have you achieved any success in this effort, and if so can you outline it in dollar terms? We are still receiving dozens of publications a week in our office from various Federal agencies, and I must say, a goodly number of them seem to result in little more than an excessive use of taxpayers' money.

Secretary WEINBERGER. Yes; I think that we have made significant progress. The most recent numbers that I have seen showed something like a one-third reduction in the number of publications last year, and we are making even more progress this year. But as you indicated there can still be even further improvement and we would be interested in taking a close look at the ones which you are receiving from HEW which are of questionable value.

Mr. MICHEL. Thank you, Mr. Chairman.

Mr. FLOOD. Mr. Natcher.

TRUST FUND SHARE OF HEW BUDGET

Mr. NATCHER. In your statement, Mr. Secretary, to the committee, you point out that the 1976 HEW budget will total $118.4 billion in outlays, which makes a little more than one-third of the Federal budget.

How much of that amount, Mr. Secretary, is new money? Your $118.4 billion includes the trust fund money, doesn't it?

Secretary WEINBERGER. Oh, yes.

Mr. NATCHER. How much of it is new money?

Secretary WEINBERGER. Maybe I don't fully understand your term of new money.

Mr. NATCHER. In other words, how much is it actually in appropriated funding that has to come in this bill? I know that your social security trust fund money is a little over $80 billion. You have railroad retirement and your other trust fund money. Actually how much new money are you requesting?

Secretary WEINBERGER. The bill before the committee is $36.7 billion.

Mr. NATCHER. That is the figure, $36.7 billion?

Mr. MILLER. That includes all HEW funds. A few of them go before other subcommittees.

Mr. NATCHER. Yes.

Secretary WEINBERGER. We do regard the trust fund as money.

Mr. NATCHER. That is correct.

Secretary WEINBERGER. And we are requiring new actions this year, something like a $7 billion increase.

Mr. NATCHER. That is correct. When you say, Mr. Secretary, to the committee that the budget for HEW is $118.4 billion without explaining that that includes the trust fund money, it sometimes surprises people.

In other words, as far as actual appropriations are concerned, that is, in funding that comes in the bill, we have $36.7 billion.

Mr. FLOOD. If the gentleman will yield, a phrase we often hear out in the field is this is bigger than the Department of Defense.

Mr. NATCHER. That is correct.

Mr. FLOOD. $118 billion.

Secretary WEINBERGER. Yes, but I don't understand, Mr. Chairman, how you can disregard the social security funds or the fact that they may be paid out of Federal funds which are classified as being in a trust fund. The total Federal expenditures that the President has sought of $349 billion includes those trust funds, and our portion of it is $118 billion and that is just under 40 percent, and the Defense expenditures are 26 percent or 90 billion.

So those are the comparable figures. The trust fund money under the law adopted in 1968 is required to be included in the unified budget and that is the way in which it is submitted.

Mr. NATCHER. As far as services are concerned in the Department, that is what confuses the people, Mr. Secretary. When you come up with this figure of $118 billion, Mr. Secretary, your statement this time before the committee goes back a little bit like the ones that you presented when you first started out from the standpoint of defending the action that you are requesting insofar as the overall budget is concerned.

"In broad outline, this plan proposes a tax reduction to provide an immediate stimulus to the economy and restraint on the growth of Federal spending to keep the deficits caused by the economic slump to a manageable size."

You go on and point out, Mr. Secretary, that a $52 billion deficit could go to $86 billion. Now, Mr. Secretary, I hope to live to see the day, that your budget is larger than the Department of Defense budget, and the Defense budget is smaller than the one before the Congress.

Secretary WEINBERGER. That day is already here, Mr. Natcher.

PRIORITIES IN THE FEDERAL BUDGET

Mr. NATCHER. That is a matter of semantics, Mr. Secretary. As far as your budget is concerned, we are going to spend most of our time, Mr. Secretary, on this amount that you have given the committee of $36,700 million. There is where we are going to spend our time. When you talk about the deficit, Mr. Secretary, and justifying the action that must be taken as far as the $52 billion deficit, I guess if you figure it up and also consider the fact that the trust funds now own about 24.6 percent of the national debt and take into consideration how much of the debt will be purchased by the trust funds, it might be more than $52 billion at this point.

Now, Mr. Secretary, when you say to the people in this country that in HEW certain reductions must take place and the President—and I am very fond of him—comes up and says that "If you will accept all of my rescissions and deferrals it will be a little over $17 billion," and then we question your people, Mr. Secretary, about Hill-Burton money, for instance, and they say we don't need any more hospital beds—we had that up here within the last 2 weeks—and we say certainly not maybe in New York City, maybe not in Detroit and Chicago but what about the poorer States? Well, they wouldn't defend it too strongly on that point, Mr. Secretary. As far as the poorer States are concerned, we need more hospital beds in those States. A lot of States do. What applies only in New York City couldn't apply in a lot of communities in the poorer States as far as a rescission of nearly $300 million in Hill-Burton money is concerned, Mr. Secretary.

When you talk about the deficit and what should be done in your Department, Mr. Secretary, I served for 10 years on the Foreign Operations Subcommittee. I stayed as long as I could, Mr. Secretary, and I got off. I couldn't stay any longer. I have voted against foreign aid bills for about 5 years and am going to vote against the next one when it is presented. Now, with hundreds of billions of dollars in foreign aid all around the world, the Department of Defense comes

in at this time and in the budget for fiscal year 1976, and requests $104 billion. In addition to that, there is $3 billion for the Atomic Energy Commission, which makes an overall total of $107 billion. All of that, Mr. Secretary, with the exception of a few dollars is new money. That is in the same category as your net $36.7 billion—that $107 billion.

Now, that is an increase of $15 billion over the budget for fiscal year 1975. I am just like you, Mr. Secretary; I think from the standpoint of the security of this country we can't take any chances. My Chairman, Mr. Flood, has served for years on the Defense Subcommittee, and without speaking for him, he will tell you that when the military people of this country come in and say "We can't take chances on this," we don't take chances on it from the standpoint of the security of this country. But, Mr. Secretary, when they come up and finally say, "You know, we have cost overruns now of $34 billion"—they finally released that 2 or 3 weeks ago, $34 billion in cost overruns. It doesn't read very good in the paper when you say cost overruns. They changed it a little bit and said it is cost increases, in weapons systems, and other matters. A little of that money is in GSA, a little of it, but cost overruns is what we call it here in Congress.

So, Mr. Secretary, when you point out about the deficits, the seriousness of this problem, and certainly I know it is serious when you have a national debt that is anticipated to go to $535 billion on July 1 of this year and to $604.5 billion on July 1, 1976.

I know this is all serious, but, Mr. Secretary, you are the Secretary of the most important Department in peacetime in our Government. The people are much more concerned about your program, Mr. Secretary, and your Department than they are about a number of other departments.

I think you are doing a good job. I say that to you frankly. But the only thing I disagree with you about is when you come in and you try to justify all these reductions and you use examples as far as HEW is concerned.

I wish you would talk a little bit about foreign aid, and a little about this Defense budget of $107 billion.

Mr. Secretary, we are going to carefully analyze your budget.

Thank you, Mr. Secretary.

Secretary WEINBERGER. Thank you.

Mr. NATCHER. Thank you, Mr. Chairman.

Mr. FLOOD. Mr. Shriver.

IMPACT ON AGED

Mr. SHRIVER. Could you furnish, Mr. Secretary, for the record how much is in this budget request for HEW for senior citizens?

Secretary WEINBERGER. Yes.

Mr. SHRIVER. If you don't have it now you can put it in the record.

Secretary WEINBERGER. We have a number of different programs, I believe somewhere in the neighborhood of about $335 million, including health, the new National Institute, and our aging programs, but, of course, in a larger sense, not in this bill, as we just discussed with Mr. Natcher, but in a larger sense all of social security is in that category and medicare is in that category, but specifically within the bill that is before the committee roughly $335 million.

[The information follows:]

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Funds for Programs on Aging
(In thousands of dollars)

I. Office of Human Development	1972 Actual	1973 Actual	1974 Actual	1975 Estimate	1976 Estimate
A. Administration on Aging					
Development of programs for the Aging	$44,552	$83,737	$306,136	$196,100	$196,100
Aging research and training	12,500	12,100	16,500	7,000	7,000
Total, Administration on Aging	67,052	95,737	322,636	203,100	203,100
B. Rehabilitation Services Administration					
Basic State Grants	8,960	8,835	11,340	12,240	12,240
Facility Improvement	200	154.5	149.4	140.13	124.2
Total, Rehabilitation Services	9,160	8,989.5	11,489.4	12,380.13	12,364.2
Rehabilitation Training	44.32	41.55	28.03	28.03	39.96
Total, RSA	9,204.32	9,031.05	11,517.43	12,408.16	12,404.16
C. Office of Rural Development	---- 1/	---- 1/	17.25 2/	22.2 2/	24.4 2/
D. Office of Native American Programs	---- 3/	---- 3/	188	188	188
Total, Office of Human Development	$76,256.32	$104,768.05	$334,358.68	$215,718.36	$215,716.4
II. Social Security Administration					
Benefit payments to persons age 65 and over from Social Security trust funds:					
Disability insurance benefits (Dependents)	$17,000	$21,000	$24,000	$28,000	$35,000
Retirement and survivors' insurance benefits	27,165,000	33,247,000	37,898,000	43,480,000	50,039,000
Hospital insurance benefits	6,108,000	6,648,000	7,310,000	9,031,000	10,305,000
Supplementary medical insurance benefits	2,255,000	2,391,000	2,587,000	2,960,000	3,380,000
Sub-total, benefit payments to persons age 65 and over from social security trust funds	35,545,000	42,307,000	47,819,000	55,499,000	63,759,000

1/ No figures are available.
2/ Figures are unreliable estimates only.
3/ During FY 1972 and FY 1973, ONAP was in the Office of Economic Opportunity.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Funds for Programs on Aging
(In thousands of dollars)

II. Social Security Administration (Continued)

Payments to persons age 65 and over from Federal funds:

	1972 Actual	1973 Actual	1974 Actual	1975 Estimate	1976 Estimate
Supplemental Security Income payments	---	---	850,000	1,860,000	2,090,000
Special benefits for disabled coal miners	271,000	612,000	664,000	673,000	735,000
Sub-total, payments to persons age 65 and over from Federal funds	271,000	612,000	1,514,000	2,533,000	2,825,000
Grand Total, Social Security Administration	$35,816,000	$42,919,000	$49,333,000	$58,032,000	$66,584,000
III. Public Health Service					
A. Health Services Administration					
1. Community Health Services	$30,502	$31,431	$25,975	$20,800	$20,800
2. Medical Care Standard	4,719	4,719	5,613	5,775	4,537
3. Professional Standards Review Organization	none	4,475	12,805	18,102	25,072
Subtotal, Health Services Administration	35,221	40,625	44,393	44,677	50,409
B. National Institute of Child Health and Human Development (National Institute on Aging)	12,505 4/	12,650 4/	17,203 4/	13,300 4/	16,190
C. Alcohol, Drug Abuse, and Mental Health Administration					
National Institute of Mental Health	4,516	2,894	2,128 (2,487) 5/	2,240 (2,421) 5/	2,434
D. Health Resources Administration					
1. National Center for Health Statistics	$ 926	$ 900	$ 872	900	1,100
2. National Center for Health Services Research	10,133	5,396	5,322	3,600	3,000
3. Bureau of Health Resources Development, Division of Facilities Utilization	61,240	41,762	38,953	45,966	43,993
Subtotal, Health Resources Administration	72,299	48,058	45,147	50,466	48,093
Total, Public Health Service	$114,541	$104,227	$108,871 (109,230) 5/	$110,683 (110,864) 5/	$117,126

4/ Figures for 1972 through 1975 represent the portion of the appropriations for NICHHD which was and is being allocated to its aging program or to the National Institute on Aging.

5/ Includes 1973 released funds.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Funds for Programs on Aging
(In thousands of dollars)

	1972 Actual	1973 Actual	1974 Actual	1975 Estimate	1976 Estimate
IV. Social and Rehabilitation Service					
A. Assistance Payments Administration.....	$1,297,519	$1,287,752	$635,409 6/	$25,707 7/	$3,670 7/
B. Community Services Administration.....	170,000	216,000	231,000 8/	306,000	334,000
C. Medical Services Administration.....	1,778,348	1,539,398	2,247,541	2,647,945	3,059,787
D. Office of Planning, Research and Evaluation.....	280	125	138	1,613	5,300
Total, Social and Rehabilitation Service.....	$3,246,147	$3,043,275	$3,114,088	$2,981,265	$3,402,757
V. Office of Education					
A. Library Resources.....	$1,015	$550	$750	$600	----- 9/
B. Adult Education.....	1,534	1,800	5,630	5,630	5,630
C. University Community Services.....	121	130	130	None	None
Total, Office of Education..	$2,670	$2,480	$6,510	$6,230	------ 9/

6/ Includes one half-year payments and costs for programs affected by P.L. 92-603.
7/ Adult programs in Guam, Puerto Rico, and Virgin Islands only.
8/ Estimate
9/ Not available at time of printing.

Mr. SHRIVER. Could we also have in the record a list of programs elsewhere in the Federal Government?

Secretary WEINBERGER. Yes, sir.

[The information follows:]

NON DHEW FEDERAL PROGRAMS WHOSE PRINCIPAL MISSION IS TO BENEFIT THE ELDERLY[1]

[Obligations in thousands]

Department/agency	Program	1975 Budget request
Action	1. Foster grandparents	$25,900
	2. Retired senior volunteer program	17,500
	3. Service corps of retired executives	400
Community Services Administration	1. Senior opportunities and services	
Department of Housing and Urban Development	1. Housing for the elderly or handicapped fund	156,178
Department of Transportation	1. Reduced fares for the elderly and handicapped	(1)
	2. Assistance to the elderly and handicapped (sec. 16–B program).	(1)
Department of Labor	1. Community service employment for older Americans.	(2)
Total		199,978

[1] Not separately identified in the budget.
[2] Included in the comprehensive manpower assistance program authorized by the Comprehensive Employment and Training Act of 1973.

Mr. SHRIVER. For the same thing.

Secretary WEINBERGER. Yes.

There are various things scattered throughout OEO still. Some in HUD.

VOCATIONAL EDUCATION

Mr. SHRIVER. That would be helpful. You are proposing to shift $125 million from the general vocational education assistance program over to a specific project approach?

Secretary WEINBERGER. That is correct; yes, sir.

Mr. SHRIVER. Would that mean a shift in the decisionmaking as to how these funds would be spent?

Secretary WEINBERGER. Yes.

Mr. SHRIVER. From local level to Federal level?

Secretary WEINBERGER. Yes; it would be substantially that way. It would continue the basic vocational grant, but we would suggest that the program for students with special needs, consumer and homemaker education, work study, cooperative education, State advisory councils, all be consolidated into a single vocational research and innovation program with the same amount of money so that the $125 million would be into that fund, which would be a major increase in that fund, but it would consolidate all of these other programs that I have mentioned.

Mr. SHRIVER. Who makes the decisions?

Secretary WEINBERGER. On that?

Mr. SHRIVER. Yes.

Secretary WEINBERGER. The State vocational people.

Mr. MILLER. I think the bulk of it is determined at the State level. There is a percentage of the funds that would be set aside where the decision would be made by the Commissioner of Education, but the bulk of it is determined at the State level.

STUDENT ASSISTANCE

Mr. SHRIVER. Why do you consider such student assistance programs as the direct loans and the supplementary opportunity grants less effective than the basic opportunity grant program?

Secretary WEINBERGER. For one thing the guaranteed student loan programs we have are causing a certain amount of difficulty. They are guaranteed loans. The direct student loans would be subjected to the same kind of problems with respect to repayments and use of the funds.

We think that the most beneficial kinds of programs to a student are those that enable him to get what amounts to a Federal scholarship, use the funds in accredited institutions as the student wishes, and to secure his education. These funds are quite properly targeted toward the lowest income groups.

The guaranteed student loan program enables us to help parents and children of middle income families, but the other programs are for very specific kinds of purposes. They are designed to be operated entirely by the Federal Government with the direct loan being made by and ultimately repaid to the Treasury. We think that basically these programs don't serve the student as well as the program which puts more decisionmaking power into his hands, such as the basic opportunity grant program.

We also believe that it is much more important to encourage the States to adopt similar scholarship programs and if we can do that the total assistance will be increased but will be increased in a flexible way that will enable the student to get the most use out of it.

Mr. SHRIVER. The people who have been operating these programs in my part of the country seem to like the mix that we have had rather than putting all the emphasis upon the basic opportunity grants.

Secretary WEINBERGER. There still would be considerable emphasis on the guaranteed student loan plan.

Mr. YOUNG. You still have considerable funds in the work-study programs. I recall about $250 million in the 1976 budget.

Secretary WEINBERGER. Yes.

IMPACT AREA AID

Mr. SHRIVER. Quite a little discussion time of the committee has been taken up with elimination or partial elimination of the impact aid program.

Just for your information, not all of the committee feels as you do or prior administrations have. But according to figures that I obtained this morning the public schools in my hometown of Wichita, Kans. currently receive approximately $650,000 in impact aid funds. Five percent of their school budget amounts to over $2 million.

Obviously if their impact aid funds are reduced by this 5 percent figure they will get nothing at all. Would that be correct?

Secretary WEINBERGER. The basic proposal that we have made is that the school district would absorb up to 5 percent of their prior year operating budget to reduce the impacted aid program and this is the B children, the children whose parents work for the Federal Government, but who do not live on a Federal establishment.

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Mr. SHRIVER. Would there be any B children programs left?

Secretary WEINBERGER. Yes; we would fund in 1975 something like 68 percent of the entitlement of B children, so that you would gradually be reducing it but you would be reducing it in a way that was designed toward eliminating it.

However, you would do it on a phased-down basis.

Mr. SHRIVER. Sixty-eight percent of entitlement?

Secretary WEINBERGER. That is the figure that I have of the percentage of entitlement of B children that would be funded in 1975.

Mr. MILLER. We would compute the 68 percent as the starting point but the 5 percent reduction takes place after that, so I think the net amount would be about $40 million for B children.

Mr. SHRIVER. $40 million for B out of what total?

Secretary WEINBERGER. We would have a 1975 figure for B children of $355 million and we would have a 1976 figure of $40 million. That is the reduction that is proposed. We would start reducing the amounts paid for the B children on this 5 percent basis annually, the point being, as you know, we do not believe that the B children actually have this degree of impact on the school system. The fact that they are there, the fact that the school systems have been relying on these Federal funds, is recognized and that is why we don't say cut it all out in 1 year but start phasing it down.

STATE EQUALIZATION PLANS

Mr. SHRIVER. As you know, Kansas is among a small number of States which have passed public education equalization plans. The administrators of these plans are having considerable difficulty because of the long delay in getting some decisions made in HEW in regard to how they are to treat impact aid funds when determining how much State aid shall go to school districts receiving such funds.

These administrators have not even been told yet if HEW considers their plans to be true equalization plans. They don't know if they qualify even partially, and if partially, at what percentage. HEW has not yet come out with a definition of local revenue under equalization plans. They cannot plan effectively, and, in the case of Kansas, if these decisions are not made and announced soon, no action can be taken because the State legislature will have adjourned.

Our State stands to lose as much as $8 million in impact aid funds if these decisions are not favorable, but their primary worry now is that no decisions have been made. When can they expect action in this regard?

Secretary WEINBERGER. I understand that the equalization provision included in the impact aid law by the Education Amendments of 1974 has been a very difficult provision to define in operational terms. The Office of Education has consulted extensively with the State and local school officials on this subject. We expect to be issuing regulations soon and hope to get this matter resolved as expeditiously as possible.

COMMUNITY MENTAL HEALTH CENTERS

Mr. SHRIVER. Mr. Secretary, consistent with the administration's opposition to an extension of the community mental health centers

program, you are not requesting funds for new centers. Extension legislation is moving forward, however. The main purpose of this legislation is to complete the coverage of the approximately 1,500 catchment areas in this country with nearby mental health centers. While this figure of 1,500 catchment areas is generally used by those in the mental health field, I have not seen a countrywide description or map showing where the areas are, which ones are now covered and which ones are not. Could you furnish that information to the committee?

Secretary WEINBERGER. I do not have the specific information with me but am sure we have it and I would be happy to supply it for the record.

[The information follows:]

9-20-74

CMHC: State Coverage as of 6-30-74

STATE	REGION	Total No. Catchment area in State	Number of Funded Centers	Total Population Funded* Catchments	Percent of Total State Population Covered	State Rank of Percent Coverage
1. ALABAMA	4	25	13	1,966	56.0	21
2. ALASKA	10	7	2	31	10.4	52
3. ARIZONA	9	14	6	1,282	63.2	17
4. ARKANSAS	6	14	13	1,694	83.5	7
5. CALIFORNIA	9	151	47	6,177	30.5	41
6. COLORADO	8	15	12	1,614	67.6	16
7. CONNECTICUT	1	22	6	830	27.1	46
8. DELAWARE	3	4	2	278	48.8	24
9. DISTRICT OF COLUMBIA	3	4	4	829	100.0	4
10. FLORIDA	4	43	18	2,889	38.1	34
11. GEORGIA	4	34	14	2,087	44.1	29
12. HAWAII	9	8	5	528	68.0	15
13. IDAHO	10	7	7	727	100.0	4
14. ILLINOIS	5	82	16	2,074	18.5	50
15. INDIANA	5	32	13	2,134	40.2	33.5
16. IOWA	7	23	6	863	29.7	42
17. KANSAS	7	16	10	1,713	76.2	12
18. KENTUCKY	4	22	22	3,127	100.0	4
19. LOUISIANA	6	33	16	1,635	43.8	30
20. MAINE	1	8	7	919	90.2	6
21. MARYLAND	3	30	10	1,234	30.8	40
22. MASSACHUSETTS	1	39	17	2,636	45.5	28
23. MICHIGAN	5	58	19	3,021	33.5	38
24. MINNESOTA	5	34	7	1,016	26.1	47
25. MISSISSIPPI	4	14	11	1,787	79.2	10
26. MISSOURI	7	36	13	1,589	33.6	37
27. MONTANA	8	5	5	698	100.0	4
28. NEBRASKA	7	11	7	860	56.2	20
29. NEVADA	9	4	1	140	25.9	48
30. NEW HAMPSHIRE	1	9	4	361	45.9	26
31. NEW JERSEY	2	49	19	2,948	40.2	33.5
32. NEW MEXICO	6	9	3	376	34.6	36
33. NEW YORK	2	122	24	5,277	28.9	44
34. NORTH CAROLINA	4	41	22	3,137	60.5	18
35. NORTH DAKOTA	8	8	5	497	79.4	9
36. OHIO	5	79	20	3,113	29.0	43
37. OKLAHOMA	6	15	5	1,124	42.7	31
38. OREGON	10	16	2	357	16.0	51
39. PENNSYLVANIA	3	85	39	5,832	49.0	23
40. RHODE ISLAND	1	8	2	204	21.5	49
41. SOUTH CAROLINA	4	15	10	2,002	75.3	13
42. SOUTH DAKOTA	8	6	2	310	45.8	27
43. TENNESSEE	4	30	12	1,923	46.8	25
44. TEXAS	6	80	27	4,266	36.7	35
45. UTAH	8	11	7	928	80.5	8
46. VERMONT	1	5	5	440	100.0	4
47. VIRGINIA	3	37	10	1,481	31.8	39
48. WASHINGTON	10	26	7	976	28.8	45
49. WEST VIRGINIA	3	14	8	1,228	68.5	14
50. WISCONSIN	5	37	13	1,840	40.3	32
51. WYOMING	8	6	3	176	50.5	22
52. GUAM	9	1	1	67	100.0	4
53. PUERTO RICO	2	18	11	1,518	56.5	19
54. VIRGIN ISLANDS	2	1	1	62	100.0	4
55. AMERICAN SAMOA	9	1	0	0	0	0
56. TRUST TERRITORY	9	1	0	0	0	0

* in thou

REGION					
61 1	91	41	5,390	44.7	4
62 2	190	55	9,806	34.6	7
63 3	174	73	10,883	46.0	3
64 4	224	122	18,919	56.7	2
65 5	322	88	13,198	29.5	10
66 6	151	64	3,096	43.1	6
67 7	86	36	5,025	44.0	5
68 8	51	34	4,223	71.5	1
69 9	180	60	8,194	34.5	8
70 10	56	18	2,091	31.3	9
US TOTALS	1,525	591	86,826	41.2%	

FEDERAL OUTLAYS FOR EDUCATION

Mr. SHRIVER. Only a portion of proposed Federal expenditures for education are in your request; other education-related programs are administered elsewhere, such as the veterans educational benefits, child nutrition programs, and others. Would you place in the record at this point the table which appears on page 140 of the special analysis of the fiscal 1976 budget showing the total Federal outlays for education for fiscal years 1974, 1975, and 1976? The total for 1976 is more than $16 billion.

Secretary WEINBERGER. We would be happy to do so.

[The information follows:]

Table I–1. FEDERAL OUTLAYS FOR EDUCATION

Purpose and program	Outlays (millions)		
	1974 actual	1975 estimate	1976 estimate
Educationally deprived children	1,460	1,599	1,755
Emergency school aid	205	207	122
Federally affected areas	559	631	371
Other ESEA	207	292	439
Salaries and expenses	77	112	105
Basic opportunity grants	49	451	502
Other higher education student support (OE)	837	1,099	1,290
Other higher education (OE)	290	260	258
Student loan insurance fund	84	176	192
Occupational, vocational, adult	570	631	646
Educational development	246	160	43
Education for the handicapped	123	125	138
Library resources	150	169	125
Other Office of Education	30	54	57
National Institute of Education	97	82	84
Special institutions	113	135	118
Student grants (OASDI)	937	1,053	1,189
Office of Human Development	414	443	467
Other HEW	106	110	123
Other	427	516	546
Subtotal, national education goals	6,981	8,305	8,570
Federal outlays—education support for other basic purposes:			
Health manpower	546	613	519
Veterans readjustment	2,914	3,377	3,091
Defense	967	1,029	1,072
Child nutrition	1,267	1,617	1,463
Other	1,112	1,324	1,247
Subtotal, education support for other purposes	6,806	7,960	7,392
Federal outlays—salary supplements	238	249	281
Total, education outlays	**14,025**	**16,514**	**16,243**
Amounts previously carried for academic research not directed toward educational objectives	1,856	2,040	2,056

FEDERAL HEALTH OUTLAYS

Mr. SHRIVER. Would you then place in the record the table on page 169 of the special analysis showing the breakdown of $38 billion in

Federal health programs for fiscal 1976? This is about $2.7 billion higher than last year and $8.5 billion higher than 2 years ago.

Secretary WEINBERGER. Yes, sir.

[The information follows:]

Table K–2. **FEDERAL OUTLAYS FOR MEDICAL AND HEALTH-RELATED ACTIVITIES BY CATEGORY** (in millions of dollars)

	Outlays		
	1974 actual	1975 estimate	1976 estimate
Development of health resources, total	4,383	5,242	5,362
Health research	2,085	2,424	2,512
Training and education	1,146	1,324	1,145
Construction	761	967	1,108
Improving organization and delivery	392	527	596
Provision of hospital and medical services, total	23,918	28,783	31,348
Direct Federal services	4,797	5,390	5,828
Indirect services	19,120	23,393	25,520
Prevention and control of health problems, total	888	1,019	989
Disease prevention and control	419	458	405
Environmental control	90	129	137
Consumer protection	378	432	446
Total, health programs	**29,189**	**35,044**	**37,699**

RESEARCH ON SPECIFIC DISEASES

Mr. SHRIVER. I am often asked by constituents, as I am sure all Members are, how much the Federal Government is spending for research on specific diseases. I realize it is difficult to pull such figures out of general research programs, but would you attempt to put something together for the record showing Government expenditures in 15 or 20 well-known diseases? Include in that the most widespread forms of cancer, diabetes, Huntington's disease, Parkinson's disease, sickle cell anemia, Tay Sachs disease, arthritis and related diseases, and I am sure there are others on which the Public Health Service receives a number of inquiries from our office.

Secretary WEINBERGER. We do have such a table which I will be happy to insert for the record.

[The information follows:]

NATIONAL INSTITUTES OF HEALTH

1975 and 1976 Program Areas of Special Concern
(In thousands of dollars)

Appropriation/Program	1974 Obligations (1)	1975 Appropriation (2)	1975 Revised Estimate (3)	1976 President's Budget (4)
NCI				
Nutrition	$2,700	$4,300	$2,700	$2,800
Cancer task forces	23,239	30,230	24,730	26,730
Smoking and health	7,420	8,600	7,500	8,000
Cancer research centers	80,715	115,834	95,699	100,699
Cancer control	34,055	50,098	45,156	45,156
Cancer construction	27,550	38,000	22,000	22,000
Combined treatment modalities	37,357	50,967	41,967	45,000
Other	306,133	393,637	328,853	354,815
Pap testing	(--)	(8,870)	(5,870)	(8,000)
Breast cancer detection & treatment	(--)	(31,083)	(24,083)	(26,083)
Subtotal	519,169	691,666	568,605	605,000
NHLI				
Arteriosclerosis	121,274	131,300	119,040	121,600
Pulmonary disease	41,445	51,330	42,561	43,550
Blood resources and thrombosis	33,469	39,400	32,309	33,820
Sickle cell diseases	16,000	16,400	16,000	16,000
Other	74,072	85,700	76,453	77,824
Subtotal	286,260	324,130	286,363	292,794
NIDR				
Dental caries	8,886	10,900	8,114	8,420
Periodontal and soft tissue diseases	10,447	11,200	8,869	9,078
Craniofacial anomalies	7,934	7,600	5,910	6,098
Pain control	1,000	1,500	1,335	1,435
Other	15,647	18,664	18,147	18,505
Subtotal	43,914	49,864	42,375	43,536

Appropriation/Program	1974 Obligations (1)	1975 Appropriation (2)	1975 Revised Estimate (3)	1976 President's Budget (8)
NIAMDD				
Cystic fibrosis	$2,525	$2,680	$2,367	$2,417
Arthritis	14,182	14,104	13,171	13,921
Cooley's anemia	1,300	1,300	1,158	1,208
Diabetes	11,097	12,997	12,208	13,024
Digestive diseases	19,901	21,817	18,288	18,836
Kidney disease	18,434	21,060	16,729	17,592
(Artificial kidney)	(3,644)	(4,670)	(3,686)	(4,000)
Nutrition	9,846	8,958	8,196	8,276
Psoriasis	992	1,048	610	600
Other	75,135	89,157	71,921	72,535
Subtotal	153,412	173,121	144,648	148,409
NINDS				
Stroke	8,086	10,910	8,578	8,805
Epilepsy	5,610	6,505	4,317	5,115
Infectious disorders of the nervous system	5,008	5,670	4,552	4,870
Parkinsonism	4,138	4,956	3,158	3,404
Trauma, spinal cord and head injury	6,309	10,550	6,555	6,746
(Regeneration)	(1,097)	(2,005)	(1,161)	(1,202)
Communicative disorders	12,164	13,760	10,433	12,359
Multiple sclerosis	4,770	6,967	5,500	5,903
Cerebral palsy	12,890	15,390	12,246	13,197
(Collaborative perinatal project)	(3,152)	(3,140)	(2,150)	(2,150)
Muscular dystrophy	6,722	8,010	6,314	6,937
Tay sachs	1,347	1,500	1,290	1,373
Other	53,783	58,280	48,972	46,246
Subtotal	120,827	142,498	111,915	114,955
NIAID				
Asthma and allergic disease centers	3,795	4,751	3,655	3,875
Hepatitis	2,286	3,000	1,885	2,150
Influenza and other respiratory infections	3,650	4,310	3,827	4,485
Venereal diseases	2,937	4,122	2,720	3,020
Other	97,809	103,269	93,390	95,181
Subtotal	110,477	119,452	105,477	108,711

Appropriation/Program	1974 Obligations (1)	1975 Appropriation (2)	1975 Revised Estimate (3)	1976 President's Budget (4)
NIGMS				
Automated clinical laboratories and biomedical engineering	$17,693	$21,229	$16,000	$16,481
Pharmacology-toxicology	23,032	25,746	22,000	22,787
Trauma	6,614	12,000	8,034	9,400
Genetics	44,285	50,400	42,340	42,483
Cellular & molecular basis of disease	48,751	55,600	47,865	48,687
MARC	4,019	2,000	2,000	2,000
Burn centers	386	1,400	1,200	2,000
Other	17,378	19,025	17,137	17,792
Subtotal	162,158	187,400	156,576	161,630
NICHD				
Aging	15,758	14,949	13,300	--
Growth and development	21,108	24,142	19,041	18,747
Mental retardation	19,789	22,754	18,864	18,892
Population	44,812	51,006	41,371	41,885
Perinatal biology and infant mortality	19,062	24,481	20,217	20,944
(Sudden infant death syndrome)	(4,684)	(5,200)	(4,700)	(4,700)
Other	4,623	4,634	5,170	5,594
Subtotal	125,152	141,966	117,963	106,062
NIA				
Aging	(15,758)	(14,949)	(13,300)	15,413
Other	(--)	(--)	(--)	777
Subtotal	(15,758)	(14,949)	(13,300)	16,190
NEI				
Retinal and choroidal diseases	10,066	10,185	7,480	8,021
Corneal disease	5,831	6,114	5,555	5,202
Diabetic retinopathy	4,200	4,995	3,741	4,010
Cataracts	3,060	3,249	2,701	3,189
Glaucoma	4,641	4,602	4,066	4,892
Other	13,252	14,988	14,078	13,887
Subtotal	41,050	44,133	37,621	39,201

Appropriation/Program	1974 Obligations (1)	1975 Appropriation (2)	1975 Revised Estimate (3)	1976 President's Budget (4)
NIEHS				
E.H.S. centers	$3,885	$5,270	$4,953	$5,644
Environmental mutagenesis & reproductive toxicology	1,214	3,635	1,585	1,770
Etiology of environmental diseases & disorders	5,331	5,490	4,175	5,180
Environmental pharmacology & toxicology	6,111	7,232	5,011	5,540
Environmental pathogenesis	1,884	2,580	1,180	998
Other	9,809	10,742	11,123	11,981
Vinyl chloride	(146)	(400)	(115)	(155)
Asbestos	(547)	(1,918)	(413)	(481)
Sulfur oxide	(660)	(830)	(602)	(785)
Red tide	(9)	(24)	(24)	(28)
Subtotal	28,234	34,949	28,027	31,113
RR				
Clinical research	41,513	42,660	41,601	41,601
Biotechnology research	12,569	12,165	11,430	11,430
Laboratory animal sciences & primate research	18,048	18,573	16,993	16,993
Minority biomedical support	7,048	7,270	7,165	7,165
Other	48,794	46,532	3,446	3,869
Subtotal	127,972	127,200	80,635	81,058
TOTAL	1,718,625	2,036,379	1,680,205	1,748,659

INCOME SECURITY BENEFITS

Mr. SHRIVER. It's an incredible figure, but 40 percent of the fiscal 1976 Federal Budget is for income security benefits. Would you place in the record the table on page 198 of the special analysis of the 1976 budget, which shows a breakdown of this $153 billion for income security benefits.

Secretary WEINBERGER. Yes, sir.

[The information follows:]

Table L-1. **FEDERAL INCOME SECURITY BENEFITS**

	1974 actual	1975 estimate	1976 estimate
Federal outlays for cash benefits (millions):			
Social security (OADSI)	54,007	62,294	68,753
Federal employee benefits	11,322	14,122	15,534
Veterans benefits	7,167	8,000	8,061
Public assistance	6,832	8,410	9,214
Unemployment insurance	5,208	13,581	17,047
Railroad retirement	2,621	2,972	3,211
Other programs	1,097	1,073	1,069
Proposed legislation included above	.....	(−60)	(−4,632)
Subtotal outlays, cash benefits	88,255	110,511	122,889
Federal outlays for in-kind benefits (millions):			
Food and nutrition	4,466	5,534	5,207
Health care	16,669	20,171	22,079
Housing	1,776	2,190	2,653
Proposed legislation included above	.....	(−255)	(−2,025)
Subtotal outlays, in-kind benefits	22,912	27,895	29,940
Total benefits	**111,167**	**138,346**	**152,829**

Mr. SHRIVER. Thank you.

Secretary WEINBERGER. Thank you, sir.

Mr. FLOOD. Mr. Smith.

HEALTH CARE DELIVERY

Mr. SMITH. Mr. Secretary, I want to ask you about something I have asked you about in previous years and that is reforming the health delivery system. It seems to me that we are never going to be able to deliver the kind of health care that is needed in this country if we don't do something in the way of reforming the delivery system. Is anything being done that would encourage us to believe that we will secure some results in the near future?

Secretary WEINBERGER. I would certainly hope so, yes, sir. We have legislation that is designed first of all to improve the distribution of health manpower, so as to secure a greater geographical distribution, emphasizing the primary care. I think over the years the Federal Government has put too much emphasis on specialization, or at least that has been the result of our programs.

We need to do a lot more to improve family care. We are going to try to secure inducements for students who will practice in areas of

medical shortage, such as extending the loan period or in some cases loan forgiveness. We have asked for an increase of about $6 million over a 2-year period for that purpose. The National Health Service Corps, which has the same kind of focus; that is, an attempt to encourage medically trained personnel to go into underserved areas, largely rural areas and some inner city areas, and to try to serve those areas with primary care, these are all things that we think should be done.

Then we have some construction funding which we are targeting specifically on health care facilities, particularly outpatient and other facilities including nursing homes, needed in the health care delivery areas.

Finally I would mention some very hopeful experiments which we have conducted this year in the use of the satellite for the delivery of medical services directly to remote areas, such as parts of Appalachia or the Rocky Mountains, particularly in Alaska, we are now able to have a patient diagnosed literally from a very long distance through the use of the satellite and very low-cost receivers, and advice can be received as far away as Juneau or even Seattle. The patient in a remote Indian village would be visable on a screen to the doctor in Seattle. These are the kinds of things we are trying to do, but I do agree with you these are areas where we do need to make substantial improvements in the delivery services and in the distribution of health manpower.

PHYSICIANS IN SHORTAGE AREAS

Mr. SMITH. I just don't think there is any possibility of bribing doctors into serving where they don't want to serve; in other words, living in a community they don't want to live in. The Sears plan tried that. It didn't work. But the latter thing you mentioned does have some promise.

Secretary WEINBERGER. It has some real hope. I certainly agree with you you can't bribe anybody to do anything he doesn't want to do in that sense and we shouldn't try, but, fortunately, there are a lot of doctors and a lot of people who would like to be doctors who are quite interested and they need some kind of financial ability to enable them to do it. We are saying in effect for those of you who would like to do this, it is urgently needed and here are some inducements to let you carry out the volunteerism that you have indicated you would like to do.

In the Indian Health Service we have asked for special bonus incentive payments to try to encourage more people to do this and I think that it is a combination of factors of that kind, but ultimately you can't and should not try to draft a doctor and say you have to serve there. But we can offer some inducements to those who are so minded but who do need some assistance for their families.

Mr. SMITH. They have tried forgiving part of the loan if they practice in a certain area, but the difference to the practicing doctor in many cases is the difference between a net taxable income of $75,000 instead of $80,000. If he is in the 60-percent bracket what does he care? Besides, his wife is going to have some say whether he stays there or not.

USE OF NURSES AND PARAMEDICS

What I am really interested in is this thing of using nurses to the extent that they are capable of performing service.

Secretary WEINBERGER. Oh, yes, sir, we are including nurse practitioners, physician assistants, paramedical people of all kinds. We have research and training grants into all of those fields to try to extend the productivity of doctors, not just in underserved areas but all over the country. Also, there is no question that the disparity between the incomes that are possible to a doctor just a year or two out of medical school and those that the Government is able to pay is a very great disparity and it is part of the same problem we have with filling vacancies in the IHS as we mentioned a moment ago.

Mr. SMITH. As you know, State health departments have been setting the medical practice rules and they simply do not permit nurses and paramedics to do the things they are capable of doing, legally.

Secretary WEINBERGER. Frequently that is the case, yes, sir.

Mr. SMITH. A lot of them may illegally permit nurses to perform service they are really qualified to perform. But this is what I am really referring to. It just seems to me that we need some direction from the Office of the President and from your office to encourage these State health departments to make the changes that are necessary in those State health department rules.

We don't have national licensure, but we do have these State rules, and in connection with that then we could use more nurses. There is a possibility of getting enough nurses so we would have some to go into the more remote areas, but your budget proposes to reduce support for nurses training.

Does that really fit in with trying to improve our health delivery system?

Secretary WEINBERGER. What we are talking about, Congressman Smith, is to try to come out, roughly in the early 1980's, with a sufficient number of personnel for all of these purposes, specifically doctors and nurses, and physician extenders, and nurse practitioners, and all the rest. It obviously and admittedly involves some estimation. We do it as carefully and as scientifically as we possibly can, but every once in a while mistakes do occur.

But the simple fact is we think that we are on a path that will produce, given the existing educational establishment and the programs that are designed to train some of these paramedical nurse practitioner groups and others, we think we are on a path that by the early 1980's will bring us the number of medical health care personnel that we need. If we have a surplus there are equal problems.

NURSE TRAINING

Mr. SMITH. How are you going to do this without nurses?

Secretary WEINBERGER. We aren't.

We have funds in our request for nurses education.

Mr. SMITH. You are looking at capitation. You eliminated them, didn't you?

Secretary WEINBERGER. No. We have $101 million for it which is not an elimination even by present standards. We have special project grants that we are asking for $155 million, which is an increase of $27 million, and in that special project grants we would place special emphasis on trying to increase the quantity and distribution of primary care physicians, physician assistants, dental auxiliary, and nurse practitioner training activities. These are the areas where we would try to increase the productivity of each doctor and to allocate the personnel where they are needed.

Mr. SMITH. The table I have here shows under institutional assistance, capitation grants—last year $34,344,000—and you are proposing no money for that this year.

Secretary WEINBERGER. No; I think you are looking at the institutional assistance with respect to nurses specifically, and what we are talking about is a program which will pick up some of that in the special projects fund, as we call it, $155 million, an increase of $27 million, and out of that we would make several grants. We obviously don't know the exact number now because we haven't seen the applications, but several grants that would expand nurse practitioner training activities and the use of nurses in a broader sense than is now the case.

Mr. SMITH. Of course, the trouble with that is that some board decides where the grants go and which applications are approved and somehow on all these medical boards the nurses are either not represented or they are represented about the same way that the stewardesses used to be represented by the pilots association.

Secretary WEINBERGER. Without any question the practice of medicine and of the allied health professions is governed by the States and we are certainly doing everything we can to encourage a wider use of nurses and nurse practitioners and I think with the numbers of doctors that are available now that some of the rather parochial opposition to what existed before is lessening, but it is and has always been strictly a matter of State control.

Mr. SMITH. I call your attention to the fact that some hospitals have nursing schools and some don't and it increases the cost of patient care at those hospitals which have nursing schools and the financial pressure is there to drop nursing education at those that have it. If we don't have some kind of assistance for those who are now able to provide a great deal of help, they are just simply not going to be able to continue to do so.

It seems to me in connection with revising our health delivery system that we just can't permit this to happen.

Secretary WEINBERGER. I share your feeling as to the importance of nurses and I think they should have and will have an expanded role as we get more and more of the special projects funds into the program of training the nurse practitioners and physician assistants.

Mr. FLOOD. Mr. Patten?

PUBLIC ASSISTANCE AND GNP

Mr. PATTEN. Mr. Chairman, I don't intend to attempt by any means to comment on all your work in HEW, but I would like to say this.

Your reasoning I believe is so faulty when you say at the present rate of increase this domestic assistance spending will be 50 percent of our gross national product.

When I ran in 1962 the Federal Government collected $93 billion. Last year the U.S. Government collected well over three times, maybe four times, as much, over $300 billion. If inflation carries us to where 5 percent of our people who always needed help, 50 years ago, 10 years ago, any other time, and they were helped through the churches, if we carry that thought through a $10,000 salary by the year 2000 it will be $40,000 and a $40,000 house will be worth $200,000.

Just in the last 10 years the gross national product is three times what it was in 1963, so that you just can't elevate the cost of public assistance and not show the inflationary factors on salaries and Federal income.

The Government has a little with all the inflation because we get a little of the benefit with the higher incomes in our tax returns.

Secretary WEINBERGER. Except we are proposing very substantial tax reductions this year, Mr. Patten.

Mr. PATTEN. Oh, Senator Humphrey is going to top that. I see by today's paper he is going to make it $30 billion. I am not concerned about that. That is a different story. What I want to point out is I read an article, a government release, last week where our wages in January were at the rate of $1.2 trillion a year. If we take the $38 billion we spend for all of HEW, it is not even 3 percent. I don't know exactly what the American people earn in income. You speak of a 15-percent increase in HEW. How about if we tried to look at it thoroughly.

One item in here is SSI for $5 billion; right?

Secretary WEINBERGER. Right.

Mr. PATTEN. That is not an increase. That is a new program. Now you have for medicare probably another $20 billion.

Secretary WEINBERGER. The increase in medicare is about $1 billion.

Mr. PATTEN. What's the total?

Secretary WEINBERGER. The total of medicare? I would guess it is roughly in the $20 billion category.

Mr. PATTEN. So that we voted a tax for that, and our people this year are going to put into the U.S. Treasury about $23½ billion. I heard what you said about the unified budget, but I don't like to call SSI, and the medicare program, when we are raising $23.5 billion taxes as part of a 15-percent increase.

And cutting gonorrhea 50 percent. This morning's radio said we have 800,000 cases, 12-percent increase. The blind I am interested in.

Secretary WEINBERGER. Could we finish with the other one for just a moment? I share your ignorance of this subject, but we are not cutting. What we are suggesting is that there should be a larger portion of the total paid by other governmental units, and that I think is entirely——

Mr. PATTEN. On that I am an old timer. Before I heard of HEW, as mayor of the city in 1934 we got our Wassermann test from our State department of health in 1934. What the State has been doing for 40 years at least in education, laboratories, statistics, is known to me.

My State had 30,000 people in custody in mental hospitals. The Federal Government didn't know what it was to help us with a nickel.

I am talking about 1937, 1947, 1957. So the way we go now with the United States taking the cream off the top when it comes to tax dollars, is what we are talking about.

There is just one other little item—alcohol. We have a lovely little project up at Rutgers. It is the only college that has it. I happened to visit it lately and I heard nothing but praise from a lot of people that watch the program, and the alcohol drinkers pay $10 billion a year to the Federal Government in taxes. Why can't you spend a couple of pennies on the few that can't take it? I think the little programs I have in my city are just wonderful. They are new, and everybody says they are good.

I don't like to see the blind and the social diseases and the alcohol programs get cut.

Secretary WEINBERGER. I am not attributing anything to the work that any single committee did, Mr. Patten, and what I do think we should point out is that the excess interest that you refer to has come about largely because of the very sizeable increase in the public debt which has had to be financed, and the only way the Government can get it financed is to pay the interest at the going rate and the going rate keeps going up as the demand increases and as a result we are paying a tremendous amount of interest.

I don't think you can call it excess interest. I think the way to phrase it is that we are paying interest on an excess debt.

Mr. PATTEN. I am not talking about that. I am talking about the bankers and the private finances of the Nation with the 11 percent and the 12 percent interest, and if you want to know what is happening in the banks I can tell you.

I sat next to a woman Saturday. I went in for a cup of coffee at a little lunch counter. I heard her say to the man, "Don't save my paper tomorrow. I won't have any money until my social security check comes in Monday."

I went to a nursing home Saturday afternoon for the 100th anniversary of a woman I have known 50 years. They had a little party. The mayor came out and a few others. There are 197 patients in there. It pains me to hear people criticized when I see so many making a sacrifice and doing a good job, because this wasn't done earlier in my lifetime. I remember we didn't handle it this way. We didn't have nursing homes.

All I see in the paper is everybody foul-mouthing and then I see how wonderful and how hard these people work, and on this very nursing home, I have right in my file now the most vile letter that some woman wrote, and I know her, and I checked it out with the superintendent and she had some vivid imagination.

She will probably write to the papers. She got fired. He fired her a week before for hitting a patient.

I was there when we first started the homes under the old age assistance. I ran around getting the people to sign the agreements to reimburse if they owned a home in 1931, 1932. So watch these nursing homes.

Mr. FLOOD. Mr. Obey.

USE OF GENERIC NAMES IN PRESCRIPTION

Mr. OBEY. Thank you, Mr. Chairman.

Mr. Secretary, last year you indicated that you intended to continue to pursue efforts in order to assure that the Government was only paying for low cost or for reasonably costed drugs in the medicare and medicaid programs and you asserted that you could fairly safely assume equivalency for most drugs under the same generic classifications.

Do you still feel that same way today?

Secretary WEINBERGER. The preliminary notice of rulemaking, proposed rulemaking, has been published in the Federal Register and we have had a comment period.

We received a lot of comments of a more or less predictable nature, but we have taken into consideration these comments and suggestions and made a few changes and the final regulations are scheduled to be published, I believe, within the month—meaning March. They then should take effect and we hope that we will be able to realize some savings with full safety and beneficial effect for the patient.

Mr. OBEY. You say by March. What is your estimate on savings for the coming fiscal year?

Secretary WEINBERGER. I think we are estimating, as I recall it, somewhere in the neighborhood of $70 million for fiscal year 1976. Then they would increase substantially thereafter.

Mr. OBEY. I would just like to commend you for taking that position. I know that there is a lot of pressure against it and I hope you stick to it and come up with some tough final regs on it.

Secretary WEINBERGER. Thank you very much. We intend to.

NATIONAL INSTITUTE OF EDUCATION

Mr. OBEY. Let me ask a few other questions. On page 7 of your testimony, you said:

> I believe that the National Institute of Education is now demonstrating that it can program its resources effectively.

What do you base that statement on?

Secretary WEINBERGER. We have had a shakedown period, as I guess is customary with a new agency, particularly a new agency that had to take over as many existing research programs under the law as this one did from other elements in the Office of Education.

Most of these have now been worked out and therefore we believe now that we will be able to take the applications as they come and examine them and allocate the available resources, whatever they may be, in a way that will, I hope, produce some better research and development and suggestions in the education field.

We also have plans to disseminate what we learn and we will, as I said to the chairman, have a new director of that agency as soon as the security clearances are completed. I believe with that, plus the very fine spirit of the council that is in the legislation that works with this institute, that we should have a much better year.

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I certainly agree that the delays and the changes in personnel and all as well as the approach of certain congressional committees in reducing the appropriations have made substantial difficulties, but I think we have a better prospect for improvement now than we have had since it started.

Mr. OBEY. So this is one area where this committee, in your judgment, has contributed to difficulties by cutting the budget?

Secretary WEINBERGER. I think that what we have here is an investment in the future of education, that with it you can produce real savings and substantial increased benefits in the whole school system.

Mr. OBEY. Let me just say this, Mr. Secretary, because you indicated earlier that you felt that the reduction which the Congress made in NIE's budget was—you said something like this—"Due to our inability to convince the Congress of the importance of this function."

Secretary WEINBERGER. That is what seemed to me to be the only reasonable explanation.

Mr. OBEY. I strongly disagree with that. I don't think there is anybody at this table, most especially the gentleman from Kansas—and we have discussed this many times—who does not feel we have to be investing money in education research, but it was simply our judgment that based upon the very vague generalizations which were presented to this committee and based upon some of the esoteric, at best, projects which seemed to be presented to this committee, we did not feel that we could in all good conscience recommend spending that kind of money given the poor performance of that Department before this committee.

Secretary WEINBERGER. Part of the problem, I think, Mr. Obey, was that they did take over by law a lot of research projects which I would not have recommended that they start, but it may very well be that the presentations weren't as effective as they should have been. In both cases we believe we will still have an improvement coming up because we will have new personnel and less old mandated research to do.

Mr. OBEY. It would be, at least in my judgment, very important, if we are going to have an understanding this year between NIE and in committee, for us to be able to question the new director when we deal with the education budget. Will he be on board by that time or not?

Secretary WEINBERGER. It is my earnest hope, if the FBI and all the other groups that run through security clearances do their job, that he will be up for confirmation and then he will be available for the committees. I think you will find a willingness to be questioned. Certainly I would strongly recommend that that be the case and I would hope he would be interested in those recommendations because——

Mr. OBEY. I see Mr. Miller shaking his head.

Mr. MILLER. I was thinking that the hearing will be written the next 2 weeks. I don't see how he could get up by then.

Secretary WEINBERGER. The normal FBI time is somewhere between 5 and 6 weeks but they have started on it. It can't be in the next 2 weeks but certainly as soon as any confirmation problems can be worked out. I think that has first call on any Presidential appointment and then following that we would recommend strongly that he put himself at your disposal.

Mr. OBEY. With something like that, again if this committee is to speedily produce an education bill, if we are to exercise our responsi-

bility in reviewing that budget, a delay like that could delay the entire education bill.

Secretary WEINBERGER. I hope it would not and I would also hope that you wouldn't feel that the way to do it is to reduce their appropriation simply because you hadn't a chance to meet or talk with the new director.

Mr. OBEY. I am sure we wouldn't feel that way but I think we would like to have some idea of where he would intend to concentrate resources and what his views are before we give anybody millions to play around with.

Secretary WEINBERGER. I would be very hopeful after you had a chance to talk with him you would share the confidence we have in him.

NATIONAL INSTITUTE OF OCCUPATIONAL SAFETY AND HEALTH

Mr. OBEY. On page 8 of your statement you indicate that the budget for NIOSH would permit annual output of standards criteria on hazardous substances to be raised from 8 to 1974 to 20 per year. Isn't it in fact true were we to adopt the budget recommendation we would be cutting those criteria back from 28 to 20?

Secretary WEINBERGER. What page did you say?

Mr. OBEY. Page 8.

Secretary WEINBERGER. The NIOSH appropriation in 1975, revised, was $28 million and we have asked for $32.2 million for 1976.

Mr. OBEY. I am simply concerned by the implication left in that statement because with the rejection by the subcommittee of the rescission requested by the administration we have been told that in the absence of an acceptance of that rescission there would in fact be 28 criteria packages being produced.

Secretary WEINBERGER. The enactment in 1975 is $32 million and if the rescissions stand permanently rejected then $4 million more would be added to the revision that we have proposed here and they probably would be able to do additional standardds.

STATE FINANCES

Mr. OBEY. On page 11, the Chairman raised this previously and I thought it was an important point that was not really responded to with any degree of specificity.

The Chairman pointed out in response to your statement about asking States to increase their support for health services programs, et cetera, et cetera that the level of surpluses for States across the country has dropped from $9 billion in 1973 to $1.7 billion in 1974 and $1 billion of that resides in the State of Texas, which doesn't leave the rest of the States in very good shape.

Let me ask you about my own State, for instance. You have been involved in State government in depth and you know what a tremendous task it is to actually reduce dollars appropriated for State operations.

In my own State our Governor reduced the State operations portion of his budget by 3 percent. He had to do that because, as you know, most States don't have the ability that the Federal Government

has in being able to finance their budgets with deficit spending. They have to present a balanced budget by constitutional mandate.

What are those States supposed to do if they have already cut their budget back below last year's level? How on earth can you reasonably expect them to meet the additional services which you are telling us they ought to meet, especially when most of those States put their budget together in the first place on the basis of unemployment estimates nationally which were far below the unemployment levels which we are likely to experience.

Secretary WEINBERGER. There is no question that all governmental units and all businesses and all individuals are having difficulties during the current situation and I think what you have to look at is the relative ability of the various units of government to pick up portions of these programs. We don't believe that the Federal Government can continue the course of steady increases at the rate we have in the past.

We do propose increases but we think that the rate of growth has to be slowed and we are asking the States, localities, or private groups to increase their support for some of these health service programs that you have mentioned.

Mr. OBEY. Isn't it a fact that if the States do pick up the services which your position implies that what this budget is really doing is forcing tax increases at State levels?

Secretary WEINBERGER. No, it isn't at all.

What it is forcing is a careful examination of the programs of a lot of States and a determination that the situation is serious enough to warrant actually slowing down some of ours.

One Governor has already done this. Some other Governors have tried to.

Mr. OBEY. Where is he supposed to go for another $148 million in Federal dollars without providing for new taxes on the State level?

Secretary WEINBERGER. Three percent is a good start and some States have done that.

By what percentage has President Ford cut the Federal operations portion of the budget by this year?

Secretary WEINBERGER. He is looking at the opposition encountered from you and others because he has recommended only an increase up to $349 billion. Most of the criticism he has had is because he has not recommended a high enough increase.

Mr. OBEY. Most of the criticism the Governors are facing are precisely the same and I say your position is unrealistic.

Secretary WEINBERGER. The basic problem is, 75 percent of the Federal budget is uncontrollable, as is 95 percent of ours, and the only way you can get hold of an increase if you allowed it to take place with the automatic factors that are in existence would be far in excess of what we have proposed. You can see the opposition that the modest reductions in rate of growth that the President has proposed have encountered in this committee. None of the rescissions that he has proposed has been allowed to stand and at that level we will have a substantially more aggravated situation than we have now.

ADVISORY COMMITTEES

Mr. OBEY. Let me ask you a question on another subject, on advisory committees. Are you aware of the interpretation that I believe the FDA is recommending now in regard to advisory committees? I am

told that FDA is suggesting, in order to get around the provisions of the Freedom of Information Act, which as you know provides public access and access by the press to advisory committee meetings and the like, that public members of those advisory boards be looked at as being in fact special Government employees apparently because if they would be looked at as special Government employees rather than public members that some of the provisions of the act could then be avoided.

Are you aware of that?

Secretary WEINBERGER. No; but I don't see how it would work even assuming that is what they were planning to do, but I have not had officially reported to me any proposals of that kind. However, as you describe them, I don't see that they would be effective for that purpose.

The Freedom of Information Act doesn't really make any difference as to what kind of classification you have.

Mr. OBEY. Senator Metcalf's committee which contacted me today about it seems to fear it would have a very serious effect.

Secretary WEINBERGER. I don't see that it would have and I also suggest that there are an awful lot of unconfirmed, unauthenticated, and plainly wrong rumors floating around about all of these things.

Mr. OBEY. I hope that is true but I wonder if you would check.

Secretary WEINBERGER. I certainly will. But I can't see at this point what difference it would make to classify anybody—as whatever the expression you use—the formal public employee or something of that kind.

The salaries and other expenses of members of the advisory committees are paid for out of the Federal Treasury and these committees are governed by the freedom of information statutes. But I will certainly look into it and see what the problem is.

[The information follows:]

ADVISORY COMMITTEE COMPLIANCE TO THE FREEDOM OF INFORMATION ACT

FDA proposed new regulations on dealing with advisory committees in the Federal Register on February 19. These may have been misinterpreted. Most of FDA's advisory committee meetings include some discussions of trade secrets which are protected under the Food and Drug Act from disclosure. This means that portions of the meetings are open, but those portions where trade secrets are considered are closed.

Under the Federal Advisory Committee Act, meetings cannot be closed if one member of the public is present. In other words, as under the Freedom of Information Act, you cannot disclose something to one member of the public and not to all. For some time now, consumer groups and FDA have both felt that there should be consumer representation on panels that consider trade secrets. Oftentimes when the final decision with respect to action on a substance is a close call, the decisive element may be an ethical rather than a medical judgment.

Accordingly, FDA has been appointing consumers to these technical panels as special Government employees, which is the same type of appointment given to all of FDA's panel members. Indeed, I am informed that virtually all members of this Department's advisory committees are special Government employees.

What seems to be happening is that various representatives of consumer groups are attending the open part of panel meetings and then are asked to leave the room while the consumer representatives who have actually been appointed to the panels are remaining behind. This seems to be the source of the allegations.

However, both the Food and Drug and Freedom of Information Acts seem relatively clear in exempting trade secrets from disclosure, and it does not appear that FDA has violated either the letter or intent of those two laws or the personnel regulations surrounding the appointment of consultants.

Mr. OBEY. I would appreciate that; and I would appreciate knowing specifically whether in fact any of the advisory committees within NIH have been suggesting the same device.

Secretary WEINBERGER. Not that I have heard of. There are provisions for closing meetings for discussion of certain items within the act and we have had requests for that from time to time and some of them have been rejected and some of them have been granted, but those are all within exemptions that are provided for in the law and to the best of my knowledge they are the same exemptions that govern the public employment generally.

Mr. OBEY. I would appreciate if you would let me know.

Secretary WEINBERGER. All right; we certainly will.

WELFARE REFORM

Mr. OBEY. May I ask you another question?

Why has the administration determined not to bring up a welfare reform package this year?

Secretary WEINBERGER. The President felt there should be no new spending programs proposed this year except in the field of energy.

Mr. OBEY. Let me suggest, because I think it relates directly to energy, it just seems to me in the absence of any welfare reform program that Congress is really handicapped—and so for that matter is the administration—because when the President proposes something on energy, people's response is, "Well, what is the effect on the poor?"

When he proposes a limitation on social security the people say, "Well, what is the effect on the poor?" If I may just quote from Mr. McCracken a couple of paragraphs, he said:

> * * * [there is a] need for an explicit, generalized, systematic income maintenance program that can give expression to society's quite legitimate concerns about income redistribution. The Congress ought to give the development of such a program urgent priority in this session. Such a system could replace the polyglot of programs we now have, restoring to beneficiaries the dignity of being income recipients rather than on the dole. Moreover, such a systematic program could then be used to handle income redistribution concerns, and we would thereby gain scope for using market forces and prices to do what clearly they do best—namely, to be the communications systems of an efficient and dynamic economy. If we use the pricing system to take care of income distribution problems, we shall continue to have neither a good income distribution program nor will we have an efficient economy nor, for that matter, an effective strategy for energy policy either.

I find it difficult to argue with that and frankly find it difficult to evaluate future import of energy programs in the absence of any concrete suggestions of the administration about how best we proceed with welfare reform.

Secretary WEINBERGER. I always find it very difficult to disagree with Mr. McCracken. He is a very able man, and I have no disagreement with that except the problem of timing.

I think the President made very clear his basic concern about new spending programs at the same time he was proposing a number of rescissions and determinations and that is to my mind the rationale for the timing that he has proposed on this.

Mr. OBEY. Assuming that no welfare program could possibly be on the books in time for this next fiscal year, wouldn't it be sensible for the administration to at least send up a plan for Congress with an effective date of a year or two from now so that we could deal with those questions in tandem. Aren't we operating blindly otherwise?

Secretary WEINBERGER. The worry the President expressed in his state of the Union and budget messages was simply that there was going to be enough trouble getting Congress to agree to rescissions and deferrals and he did not feel he wanted to confuse the issue by proposing new spending programs at the same time, and I am bound to say, in view of the actions of the first month of the Congress, that that worry appears to have been justified.

MANAGEMENT IMPROVEMENT OF MEDICAID

Mr. OBEY. May I ask just one other question?

We have been told for quite some time here on the Hill that improved management of the medicaid program at Federal and State levels is just around the corner.

I have heard some people interpret your lowering minimum Federal matching for medicaid from 50 percent down to 40 percent and being, in effect, a throwing in of the towel because of the difficulty in managing medicaid in some of the high-cost States.

What would your response be to that?

Secretary WEINBERGER. No, we certainly are not doing anything of that kind. The change in matching rate is part of the basic problem I have been discussing this afternoon and many times elsewhere and that is the need to try to get hold of this enormous increase in the total numbers of programs with which we deal.

We think we will get some savings this year from quality control programs in Medicaid. We believe that we will have such things as utilization regulations, PSRO standards, and a number of other things that will try to get at some of the abuses.

There obviously have been some. This is a State-administered program and we have been doing our best to encourage them to adopt measures that will reduce some of the abuses, some of the over-use, some of the failure to examine the reimbursements, some of the problems involved in reimbursement schedules, and some of the failures to check eligibility frequently enough. All of these things we are trying our best to persuade them to do and trying actually in addition to the reduction of the matching formula, but we have not in any sense given up trying to get a better program from them and obviously won't as long as a portion of it is assigned to our department.

EARLY PERIODIC SCREENING, DETECTION, AND TREATMENT

Mr. OBEY. As I understand it, States were subject to a 1-percent penalty reduction on the AFDC if they did not establish early and periodic screening programs.

Secretary WEINBERGER. Yes.

Mr. OBEY. And information on compliance was to have been collected in the first quarter of fiscal 1975 on that.

What is the story on that?

Secretary WEINBERGER. We haven't finished the first quarter of 1975 but we are certainly trying to improve the States' acceptance of this program. It is a very high personal priority with me and a high priority, therefore, with the Department and we are now going to use the

law which Congress gave us last July, which does provide for this specific withholding, and we hope to have something in the neighborhood of 2.5 million to 3 million children under screening, and with specific diagnosing and treatment to follow. I feel there is an enormous value to this program.

We have had great difficulty in persuading a lot of the States to either start it or to——

Mr. OBEY. What about New York?

Secretary WEINBERGER. I can't remember the specific situation in New York but we have had a number of States where I think they can be fairly characterized as having been very reluctant to start it, not sharing the high priority that we assign to it. We now have, since July for the first time, the opportunity to persuade States to adopt EPSDT as a priority.

Mr. OBEY. My question on New York is simply this.

I am told to put a program like that onboard in New York would cost about $35 million and, since the penalty would only be $18 million, I am curious as to how effective that penalty provision is for the State of New York.

Secretary WEINBERGER. Most States, as we have gathered today and will gather through the rest of the spring, would feel very strongly about losing $18 million of Federal assistance, and I would also hope that aside from the dollars involved some of the States would share the feeling I have that this is an enormously valuable, potential way of improving not only the health and happiness of the children, but the public health generally.

You can catch diseases and potential diseases by early examination and screening and treat them right away, including the defects of hearing and of speech and of sight, all manner of problems of this kind.

You could bring about a tremendous improvement in the Nation's health, to say nothing of the happiness and health of the children, by starting early and that is why we assign such a very high priority to it.

As with all of these things where there is a penalty and where there has been a number of years where this wasn't done, and this program has been on the books since 1968, you are going to have some sluggishness and some resistance, but I am very hopeful that the start and the momentum we have now will be maintained, and that we will be able to report to you before too much longer that all 13 million eligible children under the medicaid programs are effectively being diagnosed and screened and treated.

Mr. OBEY. I am too.

Mr. FLOOD. Mr. Roybal.

Mr. ROYBAL. Thank you, Mr. Chairman.

BILINGUAL EDUCATION

Mr. Secretary, because of the lateness of the hour I am not going to ask too many questions, but I am interested in your budget with regard to bilingual education. I see that your budget for 1976 provides $70 million and it is the same as the revised 1975 level.

Of this amount, about $47 million would be available to support the operation of an estimated 288 classrooms which demonstrate different approaches to bilingual education.

Have you personally seen some of these programs?

Secretary WEINBERGER. Yes; I have seen some of them. Some of them I think are very effective. We have some television programs that we have had developed in this area and some of these are receiving good reviews, and we have also some research into textbooks, teacher training, and training in specific curriculum.

I think we are going to get some very good results which we will disseminate as rapidly as we can.

Mr. ROYBAL. Then you do agree that these programs are most beneficial?

Secretary WEINBERGER. Yes; I think so.

I think the Federal Government again can perform a useful role in testing and demonstrating and doing some of the research that would be too expensive for an individual school district to do, and I think we can also then disseminate the results and let the school districts pick up those portions they wish to.

Mr. ROYBAL. If this is the case, then why is it being curtailed?

Secretary WEINBERGER. I wouldn't say it is being curtailed.

We have a $70 million request for bilingual education and we had $58 million in 1974, $69 million in the revised 1975, so that I wouldn't say that it is being curtailed.

Mr. ROYBAL. But the level is the same as the 1975 level.

In other words, you have not increased your level of funds.

Secretary WEINBERGER. We have increased it slightly. It is a slight increase. It is about $69.2 million to $70 million, roughly what we are talking about.

Mr. ROYBAL. How much of an increase was it?

Secretary WEINBERGER. From $69.2 to $70 million.

Mr. ROYBAL. That is not much of an increase.

Secretary WEINBERGER. Not much, but some. But the maintenance of that kind of expenditure in this sort of year is an indication that we attach considerable importance to that.

Mr. ROYBAL. Inflation alone would eat up pretty much that amount.

Secretary WEINBERGER. You don't always describe your commitment to a program by the amount you add to it. We think it an important program but we think substantial use can come from the expenditure of $70 million and that is why we have requested it.

Mr. ROYBAL. But, nevertheless, at this time it is being curtailed by the mere fact it isn't increased sufficiently.

Secretary WEINBERGER. I don't think we can necessarily say that because we aren't entirely certain that all of the $69 million of last year was effectively and efficiently used and we hope to make sure that all of the $70 million, or at least a larger share of it, will be.

I don't think you can measure these things precisely by the amount of dollars you request. We have a high priority for bilingual. It is a necessary subject. There is a Supreme Court obligation to improve the bilingual capability of the schools and we are trying to join them in doing this.

Some more will have to be done locally, of course, and we are increasing the general Federal aid to education so they can take some of it from there, but this appropriation isn't the sole measure of the importance we attach to bilingual education.

Mr. ROYBAL. I am glad to hear you say that it is not the sole measure, but nevertheless I find that there has not been a sufficient increase in my opinion to justify the need.

Secretary WEINBERGER. Of course, to narrow down to the $52 billion deficit, we had to go back and see what we could reduce. Rather than simply adding to the deficit by increasing every program in which there is some interest or which is of some importance.

Mr. ROYBAL. Even with a $52 billion deficit, we are making available under another appropriation moneys to foreign countries in excess of $500 million for education. We are also spending more than $47 million just to train military people that come here to the United States.

Then they go back to their respective countries well trained in the use of sophisticated military equipment. They then request it. We in turn make that equipment available to them through various financial institutions where they pay an interest rate of 4.5 percent.

This complete cycle does affect the tremendous deficit that we have.

Secretary WEINBERGER. Some of the foreign aid to education does come home to benefit the bilingual programs in the form that people who have received the benefit abroad come here and are helpful in these programs.

Mr. ROYBAL. How does that happen?

Secretary WEINBERGER. It is an indirect result but if you spend some of the foreign aid money, as we do, for educational projects in other lands, some of the people who benefit from that do get the encouragement and the desire to come to this country, when they do come to this country they increase our bilingual capability by giving us more teachers who are able to conduct some of the bilingual and bicultural education courses and programs we have.

Mr. ROYBAL. I can see that this can happen but for all practical purposes it isn't becoming effective immediately. It could happen in the future, couldn't it?

Secretary WEINBERGER. We have to deal in long-range hypothesis in many areas such as this. But there is no question, Mr. Roybal, that bilingual education is an important, high-priority, and necessary program, and I think that the commitment of $70 million is a substantial commitment to it.

Mr. ROYBAL. We happen to disagree with the amount. I think we do agree with the fact that bilingual education is most beneficial. I have seen the results of these programs not only in California but in other States. Youngsters that I visited just 2 years ago spoke no English at all, just Spanish. Today they are bilingual to a great extent, speaking both Spanish and English.

When he gets to the college level—this particular youngster being already fluent in both Spanish and English—can take French or some other foreign language and be like most Europeans who feel educated only after they speak three or more languages.

Secretary WEINBERGER. I agree.

I wish we had many more States that required foreign language to be taught in the public school system and when I was in the California Legislature and in other areas of that government I got a bill passed that did just that. It lasted just 1 year and the educational establishment decided that they did not wish to maintain it.

But I do believe it is necessary. The multiplier effect of some of the things we are doing is very great. We have television programs that once they are paid for, and we have bought and paid for a substantial number, can continue year after year to bring about some of the benefits of bilingual training without additional cost.

EDUCATIONAL TV PROGRAMS

Mr. ROYBAL. Let us take the television programs for just a minute.

You are planning for 1976, $7 million for educational television programs. Then you go on to say that the support will provide moneys for the children's television workshop—this was the one that produced "Sesame Street," and "Electric Company"—and for other programs.

Does this mean that the $7 million is already earmarked for Sesame Street and other programs?

Secretary WEINBERGER. No; it does not. Those are illustrations only. We had, I think, something like $6.1 million in one bilingual Spanish-speaking program alone.

Mr. ROYBAL. What was that?

Secretary WEINBERGER. That was a program called BC–TV and we paid for some 65 programs at what I consider to be a very high cost.

Mr. ROYBAL. You had $6 million in that program?

Secretary WEINBERGER. Over about a 3-year period, I think, and that produced 65 programs which can be used for many years, year after year. We have recently given a grant to a bilingual program originating in Texas that will be played on the public television system as well as the commercial systems, again with preliminary indications that it will be extremely effective.

Mr. ROYBAL. Have you taken into consideration these programs when you propose the $7 million budget?

Secretary WEINBERGER. Yes. We have asked for $7 million and from that $7 million there will be some allocated for the bilingual programs this year as well as for programs such as "Sesame Street" and the "Electric Company" which have a good bilingual effect, too.

Mr. ROYBAL. How much of the $7 million dollar budget is already earmarked?

Secretary WEINBERGER. This is 1976 money and nothing is earmarked. This is a request and then we will apply applications that come in against it.

Mr. ROYBAL. By we, you are saying your Department does?

Secretary WEINBERGER. Yes, sir.

Mr. ROYBAL. So I take it then that you are cognizant of the fact that there are other programs besides Sesame Street?

Secretary WEINBERGER. Oh, yes. That is just cited as an illustration and we have over the years put a substantial amount of money into it. It has had, as you know, an enormous worldwide reception and I think has had a good bilingual effect from the point of helping to

instruct in a number of different areas English to children who come from foreign language backgrounds, just as we have done with other ones we have sponsored. For example, the Spanish-speaking television programs have proven very helpful to English-speaking children to enable them to acquire understanding and appreciation of another culture and another language.

Mr. ROYBAL. My understanding then of the subject matter is that the $7 million that you are requesting for this purpose also includes or does include all educational programs, including bilingual programs.

Secretary WEINBERGER. That is certainly correct, but that is not the extent of it because there are some other programs in the Office of Education funds which can be used for various forms of educational television and educational radio.

Mr. ROYBAL. But that would depend on your recommendation.

Secretary WEINBERGER. Yes, indeed. But the authorization that we have is broad enough so that if those programs are funded and if this $7 million is funded we will be able to use this and more for educational television and radio and certainly a large portion of it——

Mr. ROYBAL. If you recommend it.

Secretary WEINBERGER. Well, these are responses to applications and in the past we have granted, as I said, some $6 million for a single series of educational television programs involving the Spanish-speaking which was this BC–TV program, and that has given us 65 separate programs of, I think, a half hour each and they are available for 10, 15, 20 years because the subject matter of the language doesn't change.

RIGHT-TO-READ AND FOLLOW THROUGH PROGRAMS

Mr. ROYBAL. One other thing that I feel you are funding at a reduced level, even though it is the same as the 1975 revised level, is the Right-to-Read program and the Follow Through program, the Right-to-Read $12 million, while the Follow Through program has been reduced from $47 million, which is the 1975 revised level, to $42 million in 1976.

Why is that being reduced?

Secretary WEINBERGER. With respect to the Right-to-Read and the Follow Through programs, first of all, these are good programs and we think that they should be funded.

Second, we can't make increases in everything and we try to allocate the priorities as best we can and one of the reasons for feeling that the $12 million would be sufficient for the Right-to-Read program is that there are other authorizations under the Education Office which will enable us to encourage more reading.

There are freer funds for the States allocate to this purpose, and with respect to the Follow Through program the same is true. You are trying in the Follow Through, which is the second stage of the Head Start program, to give special encouragement to children whose home backgrounds indicate they could benefit from it, and we have requested $41.5 million specifically for that purpose. Then there are other broad authorizations through the Education budget which could have sums allocated to this purpose.

It is a matter of trying to keep the basic total increase of the whole Department somewhere within reason and it is brought about by the overall necessities of the Government and something I think we can't escape from, that if we are to have fiscal restraint there is just no doubt our Department has to share in that effort.

Mr. ROYBAL. I agree that somewhere down the line we are going to have to cut down certain links.

Secretary WEINBERGER. The only point is the sum of these individual programs. We have 300 of them and we have to hit each one.

Mr. ROYBAL. I think that we must start cutting down, as one of my colleagues has already said, some of our excessive military spending, including funds that are made available through the foreign aid bill. That, of course, is not your responsibility.

Secretary WEINBERGER. No. I have a very large jurisdiction, but it does not include foreign aid or the Defense Department.

Mr. ROYBAL. I am sure that you are happy about that.

Secretary WEINBERGER. We have quite enough to do to keep us busy.

Mr. ROYBAL. That is all, Mr. Chairman.

Mr. FLOOD. Mr. Conte.

Mr. CONTE. Mr. Secretary, I want to welcome you here to the committee and certainly congratulate you on the fine job you have been doing as Secretary of the HEW.

PRIVATE COLLEGES

Mr. CONTE. I have one question that really troubles me.

I have a lot of private colleges in my district and a good many of them are in trouble.

Secretary WEINBERGER. I think that is true generally. That is a very serious situation if you believe, as I do, in the need to keep some diversity in the education system and to have private colleges.

Mr. CONTE. What are we going to do about it?

Mr. FLOOD. Pennsylvania is one of them, too.

Mr. CONTE. I know.

Secretary WEINBERGER. We have a constitutional problem in some but not in all. But we do have, as you have noted, a recommendation from the President with respect to his energy program: The proposal that we put back into the economy through various means—the tax system for the most part—some of the dollars that would be required to be spent by the increased cost of fuel.

It was pointed out very early that this would not benefit the private colleges because they don't pay taxes so they couldn't get it back through the tax system and there has been some very intensive work in our office and at the White House in trying to close this gap in the administration program and I think that in a very short time we will have a proposal that will do that.

This won't address all of the problems; but it will mean that the higher fuel costs that will be occasioned by some of the problems that gave rise to the energy crisis in the first place can be offset in private colleges as well as in public institutions, that is, private, nonprofit institutions.

Mr. CONTE. I know we have talked to Frank Zarb and he is very sympathetic about it. Is there anything else that we could do to help the private colleges?

PROGRAMS AVAILABLE TO PRIVATE COLLEGES

Secretary WEINBERGER. Of course, the Basic Educational Opportunity Grant program allocates funds to the student and lets him pick the college that he wants to go to and if he picks a private college that is perfectly all right. He gets his grant.

The guaranteed student loan program applies to students who go to private colleges. So does the student aid portion, which is a very large part of the educational budget and is available for students who wish to use it at private institutions.

So the continuation of those programs at the level we have proposed, I think, will be of help to the private institutions. There is no proposal for a direct allocation of funds to them, but for the most part if there is student assistance which is available for students who want to use those colleges we feel this will be of some help.

Basically, what we are trying to do for the whole economy will be of assistance, that is, to try to get the inflation rate down and to try to stimulate the economy. I think one thing we have to make very clear, is that we never change the present tax advantage that comes to a person who makes a gift to a private educational institution; and there are always proposals for eliminating that as a so-called loophole.

I don't think it is a loophole at all. It helps us maintain the private institutions, and I think it is very essential that we do keep private institutions, so on the negative side I hope nobody will change that gift provision although there are proposals floating around each year that always try.

But through our student aid, basic educational opportunity grant, and guaranteed student loans programs, we will get some of the increased energy cost back into the private nonprofit institutions. These are things we are working on now that I think will have some effect.

LIMITING "UNCONTROLLABLE" COSTS

Mr. CONTE. Mr. Secretary, there are several proposals to control the so-called "uncontrollable" expenditures in the income security area, including the limitation of cost of living increases in some of these programs to 5 percent. How realistic do you think these proposals are given the present rate of inflation, and what will be the impact on the rest of your budget if these ceilings are not approved? Are you going to try to squeeze the difference out of the "controllable" expenditures?

Secretary WEINBERGER. We are hopeful that the Congress will agree with us on the necessity to restrain Federal spending and approve our proposals. If all of our legislation proposals were turned down though, I think something like $7.2 billion would be added to 1975–76 spending—the price tag on just the 5 percent limit on benefits is about $2.6 or $2.7 billion. Obviously, it would not be possible to "squeeze the difference" out of the controllables as the total outlays which will occur in 1976 from new spending authority will only be about $6

billion. I could not speculate now what actions we might propose if Congress does not go along with our proposals.

NURSING HOME ABUSES

Mr. CONTE. Mr. Secretary, there have been reports in the newspapers over the past several months of tremendous fortunes being made by owners of nursing home chains, who are making a fortune off of the medicaid system. Has your Department begun an investigation of these abuses of the medicaid system by unscrupulous nursing home owners, and do you have any proposals to deal with the problem?

Secretary WEINBERGER. First let me mention that we believe that most States are administering the nursing home programs in a reasonable manner and the majority of these homes are meeting Federal and State standards. However, when we or the States do find a nursing home that is not meeting the standards we terminate their certification and if illegal practices are suspected we notify law enforcement officials for further investigation. While we do not think provider abuse is as widespread as reports would indicate, I agree with you that greater efforts must still be made to protect the patients. Because of this belief we are creating a new fraud group in SRS specifically to identify provider abuse under State medicaid plans. This branch will monitor State compliance with enforcement provisions and regulations and will conduct investigations into alleged provider abuse, particularly in skilled nursing facilities. Where they find evidence of abuse, the case will be referred to the appropriate law enforcement authorities for further investigation. In addition, two new systems are being set up to monitor the deficiencies in nursing homes throughout the Nation and to uniformly rate nursing homes. I think that these new efforts both at the Federal and State levels will definitely result in better protection both for the patient and the medicaid system.

REIMBURSEMENTS TO STATES FOR MENTAL HEALTH SERVICES

Mr. CONTE. Mr. Secretary, in the February 8th issue of National Journal, there was a report of a dispute between the Alcoholism, Drug Abuse, and Mental Health Agency on one hand, versus the Social and Rehabilitation Service and Social Security Administration on the other. The matter at issue was over reimbursement or ADAMHA services by the other two agencies. Mr. Secretary, in previous appearances before us, you have suggested and advocated third party funding for certain ADAMHA projects. Would you tell us how you resolved this dispute, if you have made a decision, and whether it is consistent with your previous statements on this subject?

Secretary WEINBERGER. The issue was basically not over the policy of requiring third party reimbursements. It was a question of what services the medicaid and social service programs in SRS could reimburse and at what dollar level. In the case of the dollar level, the issue revolved around the question of how the HEW staffing grants to the community mental health centers would be counted. About a month ago we resolved that by deciding that SRS should continue to

reimburse only for the proportion of costs not financed by the staffing grant.

As for which services can be reimbursed, the State have wide latitude in their medicaid and service programs. Although, as we develop regulations to implement the new title XX social services legislation, we will be taking a close look at the question of CMHC services.

VACANCIES

Mr. CONTE. Mr. Secretary, I believe that there are still a number of important Federal positions either vacant or filled by acting personnel in the health field. If I am not mistaken, these include the positions of Assistant Secretary for Health; the Directorship of the National Institutes of Health; the Directorship of the National Heart and Lung Institute; and the Directorship of the National Institute on Aging. What is the cause of the delay with these appointments, and what is being done to fill them as soon as possible with the appropriate qualified individuals.

Secretary WEINBERGER. I recently made nominations to the President to fill the positions of Assistant Secretary for Health and the Director of the National Institutes of Health. It is my understanding that the President soon will propose his selections for these positions for confirmation by the Senate.

The National Institutes of Health has established search committees to identify the most qualified available candidates for the Directors of the National Heart and Lung Institute and the recently created National Institute on Aging. I anticipate that this task will be facilitated by the appointment of an NIH Director.

HUMAN RESOURCES VERSUS NATIONAL DEFENSE

Mr. CONTE. Mr. Secretary, the administration has sent up legislative proposals to reduce budget outlays in 1976 by some $8.1 billion in the human resources area. At the same time, the administration is requesting an $8.2 billion increase for military obligations and foreign military assistance. As the person with responsibility for administering the greatest part of our human resources programs, do you honestly feel that the 1976 budget accurately reflects the needs of our people and the priorities of this Nation?

Secretary WEINBERGER. As I said in my opening remarks, we have proposed a budget that is over $8 billion higher than 1975. It is a budget where we have proposed restraints on its growth, not overall reductions.

And, I do not believe that our proposal to limit growth in the budget overturns the Nation's priorities nor will create hardship. On the contrary, the real hardship on the American public will occur if Congress does not enact legislation to restrain costs and severely limit Federal spending.

FISCAL ABILITY OF STATES

Mr. CONTE. Mr. Secretary, you are asking the States to assume a large share of the financial burden of human resources program, in order to maintain constant levels of service. Do you have any indication that the States are capable of assuming greater burdens for these programs?

Secretary WEINBERGER. We did not go out and canvass the States if that is what you are asking. We realize there are indications that show that previously reported State surpluses have been utilized and that the States are saying they cannot maintain current levels of expenditure. What isn't revealed by these reports, though, is the ability of the States to reorder their own priorities by cutting back on less important programs or the degree to which the States can raise additional revenues. What we are saying is that the States are in a relatively better position to assume more responsibility for financing programs than is the Federal Government. To do this, the States will have to carefully evaluate all their ongoing activities just as the Federal Government is doing.

The changes we have proposed would require less than a 1-percent shift in funding by the States either by redirection or raising new revenues. With the fiscal relief provided to the States by the Federal takeover of State public assistance programs for the aged and disabled and the general revenue sharing program—which at later report has enabled over 80 percent of the States to either reduce taxes or hold them even—the States should be in a relatively good position to accomplish this.

Mr. CONTE. You say that your proposals would require less than a 1-percent increase in State funding. How much is that in dollars? How does that compare to the additional $3 billion which you say will be available to State and local governments in 1976?

Secretary WEINBERGER. Exclusive of Federal grants, it is estimated that State and local governments will spend about $195 billion in 1976. The HEW budget for 1976 proposes to shift approximately $1.6 billion, which is about 1 percent of the $195 billion in State funds. The $3 billion figure that I referred to in my statement is the increase in total Federal aid to State and local governments anticipated in 1976. This is the net amount after adjusting for the proposed changes in HEW funding to the States.

HEALTH PLANNING

Mr. CONTE. You are proposing $75 million in fiscal years 1975 and 1976 to make the transition to the new health systems agencies and State planning bodies. Is this amount really adequate to get this system in place by the deadline, and prevent gaps between the demise of the present system and the beginning of operations under the new one?

Secretary WEINBERGER. We have already started the process to implement the new program. I recently sent letters to all the Governors asking them to begin designating the health services areas. And, we believe that our present timetable will enable us to meet the July 1976 deadline specified in the law. Our budget requests in 1975 and 1976 assume the transition from old to new will take place in this timeframe and the funds requested are sufficient to maintain existing organizations until the new system is in place.

NURSING HOME STANDARDS

Mr. CONTE. You say that you are proposing an accelerated effort to enforce standards for the nursing homes which receive reimbursements from medicare and medicaid. That's great. I think that these standards need to be more strictly enforced. But at the same time you

are proposing cutbacks in such programs as Hill-Burton, which among other things permits renovation and upgrading of nursing homes. What good is better enforcement if there isn't a way for people to meet the standards?

Secretary WEINBERGER. The Congress discontinued the old Hill-Burton, which among other things permits renovation and upgrading of nursing homes. What good is better enforcement if there isn't a way for people to meet the standards?

Secretary WEINBERGER. The Congress discontinued the old Hill-Burton program, but under its replacement, we have requested $100 million in 1976 and I believe that some of these funds are specifically for eliminating or preventing safety hazards. Also, certain kinds of capital improvements can be depreciated over time and reflected in the costs for reimbursement under medicare and medicaid. And, I believe that HUD has some loan programs which also fall in this area.

So, there are programs where the Federal Government does help. But I do not think that the whole burden for correcting deficiencies should be borne by the Federal Government. The homes themselves should have the major part of the responsibility.

NIH BUDGET

Mr. CONTE. You say that you are proposing an increase of $72 million over the 1975 budget for the National Institutes of Health. But isn't that figure actually $279 million below the amount appropriated for 1975?

Secretary WEINBERGER. Yes. That would be correct if the Congress does not approve the President's proposals for 1975.

Mr. CONTE. Were these reductions based upon studies which indicate that programs were not achieving their purposes at the National Institutes of Health? If not, how were the reduction decisions reached?

Secretary WEINBERGER. NIH research is an important priority and I believe that this is quickly borne out when you consider the $1.8 billion proposed budget. Certainly the budget isn't as large as some would like to see; but, in the current economic situation some belt tightening has to be made—even so, the 1976 NIH budget is up over both 1974 and the 1975 revised level.

Mr. CONTE. Obviously some of the National Institutes are being cut more than others from the 1975 appropriated level of funding. What standards do you use in determining which institutes get cut, and by how much? Do you rank your priorities among the various institutes?

Secretary WEINBERGER. The 1976 budget was based upon the President's proposed funding levels for 1975 not the actual appropriation which the President has requested but reconsidered. The final appropriation was enacted in December after the 1975 decision had been made, and it did not enter into the decisionmaking on how much funding should be allocated to each institute for 1976. In 1976, each of the institutes would be up over the revised 1975 level.

Mr. CONTE. Since most research projects are multi-year efforts and require the assurance of stable financing, won't these budgetary decreases at NIH be disruptive to almost all of their research efforts? How can you localize the effect of these budget cuts to only those projects which you consider "low priority?"

Secretary WEINBERGER. If you are referring to 1976, we are not proposing any cuts. There are reductions proposed for 1975, but most of these are increases in funding levels or in funds for new research projects which would not be spent under the President's plan. There are some reductions in the 1975 base but I would not consider them to be disruptive. A careful review of ongoing grants can identify unnecessary costs and isolate grants that have been going on that haven't been productive. Effective management of the research dollars at the proposed level of spending is possible without causing a disruption to the overall NIH research effort.

PROGRAMS PROPOSED FOR TERMINATION OR PHASEOUT

Mr. CONTE. Mr. Secretary, in last year's hearings you provided for us a listing of the programs which you were proposing for termination and phaseout. In many of those programs, this committee went ahead and continued funding. Would you again provide us with a list of the programs which you are terminating or phasing out this year?

Secretary WEINBERGER. I have such a list here with me and I can leave it with you now if you wish.

PROGRAMS WHICH THE 1975 REVISED BUDGET OR
THE 1976 BUDGET PROPOSES TO PHASE OUT

(Dollars in Thousands)

AGENCY/PROGRAM:	Appropriation or Continuing Resolution	1975 Revised	1976
HEALTH:			
Health Services:			
Comprehensive health grants to States	$ 90,000*	$ 67,500	$ --
SIDS Information dissemination	2,000	--	--
National Institutes of Health:			
General research support grants	47,775	7,165	7,165
Mental Health:			
Community Mental Health:			
Staffing centers	172,053	172,053	135,363
Construction	--	--	--
Health Resources:			
Comprehensive health planning	41,883*	--	--
Regional medical programs	74,589*	--	--
Health Professions:			
Capitation	150,000*	124,600	101,100
Start-up grants	4,700*	4,620	3,000
Direct loans	36,000	30,000	20,000
General scholarships	6,900*	6,900	3,500
Nursing:			
Capitation	34,343*	--	--
Start-up/conversion	--	--	--
Financial distress	4,750*	--	--
Direct loans	22,800	18,000	9,000
General scholarships	6,000*	6,000	4,000
Traineeships	13,016*	--	--
Research/training	7,191*	--	--
Public health	20,520*	--	--
Allied health	35,013*	--	--
Medical facilities construction:			
Old "Hill-Burton"	187,340*	--	--
Health teaching facilities construction	114,000*	--	--

* Indicates amount available under the Continuing Resolution.

	Appropriation or Continuing Resolution	1975 Revised	1976
OFFICE OF EDUCATION:			
Elementary and Secondary Education:			
Follow-through	53,000	47,000	41,500
Environmental education	1,900	1,900	--
Impact Aid:			
Payments for "A" children	224,000	224,000	162,000
Payments for "B" children	355,000	355,000	40,000
Emergency School Aid	258,193*	101,000	101,000
Education Professions Development	19,239	8,139	5,212
Library Resources:			
College library resources	9,975	--	--
Training/demonstrations	3,000	--	--
Undergraduate instructional equipment	7,500	--	--
Higher Education:			
Supplemental opportunity grants	240,300	240,300	--
Direct loans	329,440	329,440	8,960
University community services	14,250	900	--
Aid to land grant colleges	12,200	2,700	--
Veterans cost of instruction	23,750	--	--
State post secondary educ	3,000	800	--
Public service fellowships	4,000	--	--
Mining fellowships	1,500	--	--
Ethnic heritage	1,800	--	--
SOCIAL AND REHABILITATION SERV:			
Social Work Training	8,900	--	--
Vocational Rehabilitation innovation and expansion grants	23,000	--	--
Cuban Refugees	87,000	87,000	40,300
HUMAN DEVELOPMENT:			
Aging training	8,000	--	--

* Indicates amount avialable under the Continuing Resolution

NIH MORALE

Mr. CONTE. Mr. Secretary, there have been continued newspaper accounts of morale problems at the National Institutes of Health, particularly with regard to the allocation of funds between the institutes. There have been charges made that such allocations are made by the Office of Management and Budget on political grounds, rather than for any particular medical or scientific basis. Could you respond to these cases?

Secretary WEINBERGER. First of all, the Office of Management and Budget does not, except for the Cancer Institute, decide what funding level each institute should have. That is done by NIH within a total allowance set by the President.

I also have read and heard of the so-called morale problems at NIH. Frankly I do not believe that the picture is as grim as it is made out to be. The problems that there are, though, are caused by many factors the primary one, I think, begin the fact that in the past, NIH received just about everything they asked for. But this is no longer possible concerning the current economic crises. There are going to have to be restraints on spending and the researchers will have to share in them.

MATERNAL AND CHILD HEALTH

Mr. CONTE. Mr. Secretary, you are proposing a fairly large cutback in maternal and child health programs of the Health Services Administration. As you know, I have a special interest in these programs, particularly as they affect research into the sudden infant death syndrome. Would you tell me why you are proposing such large cutbacks in this area?

Secretary WEINBERGER. We are not proposing that the level of services be cut back. What we are suggesting is that more of the responsibility for financing activities such as these should be assumed by the States and localities. For the maternal and child health programs, we have submitted legislation to change the Federal matching rate from 50 percent to 40 percent. Research into the cause and prevention of sudden infant death syndrome, though, isn't affected by our proposal. I believe that NIH will be spending about $5 million on SIDS research in 1976, about the same level as this year.

NIH FELLOWSHIP AND TRAINING GRANTS

Mr. CONTE. Mr. Secretary, the National Research Act authorized fellowships and grants for training at both the predoctoral and postdoctoral levels in biomedical fields. Particularly as they affect the National Institutes of Health and the Alcohol, Drug Abuse, and Mental Health Administration, have regulations for these fellowships and grants been issued yet? If not, why not? If they have been, do they cover both predoctoral and postdoctoral training, and grants to both institutions and individuals?

Secretary WEINBERGER. Both regulations and announcements have been issued covering both predoctoral and postdoctoral training and institutional and individual awards. However, discussions are still

being held regarding the precise mix of funds among the various training categories you mentioned.

Mr. CONTE. Mr. Secretary, for the past 3 years the Department has been trying to phase out most training programs in the health field. When we had hearings on the health rescissions, we were told that there were funds available for such training in the Office of Education. Would you care to tell us what funds, and how much money, is available in the Office of Education to provide training fellowships and grants for predoctoral and postdoctoral training in the biomedical fields? Would you compare this with the amount available under existing training programs in the health agencies?

Secretary WEINBERGER. What we referred to was the guaranteed loan program where students go to private lending sources for an educational loan. The Federal Government then will guarantee up to $2,500 per year, $10,000 in total. And, depending upon his family income, the government will also subsidize the students interest while he is in school. This program is available to any eligible student and there are no limits on the number of students who can recieve loan guarantees under the program.

PROJECTED NEED FOR HEALTH MANPOWER

Mr. CONTE. Mr. Secretary, would you supply us with an estimate of health manpower needs for the next 5 years or so? How would such needs be affected if we pass a national health insurance program?

Secretary WEINBERGER. Estimating requirements for health manpower is extremely difficult largely because there is no consensus on the number of various types of health care workers needed to provide optimum, adequate, high quality, or any other acceptable level of health care. However, the Department has projected that the 1980 requirements for physicians could range from 394,000 to 478,000. For dentists, the 1980 requirements could be between 118,000 and 156,000.

A major study on the impact of the administration's comprehensive health insurance proposal is nearing completion and it will probably show that manpower requirements might increase on the order of 12 percent in physicians and 6 percent for dentists.

DECENTRALIZATION

Mr. CONTE. In recent years there has been increasing decentralization of many of your programs, particularly in the mental health field. As I understand it, your regional office administrators are responsible not to the agencies whose programs they administer, but directly to the Assistant Secretary for Health. I think that this system suffers from a lack of accountability. There is no way, for example, to make sure that the funds appropriated for mental health programs are actually going for mental health. There have been complaints about the competence of the regional office administration. If decentralization is increasing, could you tell me how you propose to maintain and/or restore both program and funding accountability?

Secretary WEINBERGER. When we reorganized the regional offices in 1974, we established the position of regional health administrator to

serve as the principal health official in the region. We felt at the time, and we still do, that it is important that there be a single focal point within the regions to assure an integrated approach to the region's particular health problems. Close coordination is maintained, though with the various health agency programs to assure the accomplishment of their program objectives.

REDUCTIONS IN HEALTH PROGRAMS

Mr. CONTE. Mr. Secretary, you are proposing a reduction of about 20 percent in grant programs for the direct delivery of health care, including neighborhood health centers, alcoholism, and community mental health centers. Would you explain why cuts have been made in these areas, in which there appears to be increasing rather than decreasing need?

Secretary WEINBERGER. Yes sir, we agree that these health activities are important. We have proposed reducing the amount of direct Federal support but are not suggesting that the level of services be cut. In most instances we believe that the reduction in grant funding will be made up by increased reimbursements from third party sources—medicare, medicaid, private insurance, and so forth. What cannot be met by increased reimbursements, the States and local communities should be able to pickup.

Mr. CONTE. You are proposing a reduction in project grants for communicable disease prevention and control activities and funds targeted toward the prevention and control of substance abuse and mental illness. Do you believe that we have already solved these problems? If not, how do you justify a decrease in support for such programs?

Secretary WEINBERGER. No; we are not implying that these problems are solved because of the proposed reductions. There are two things involved. In many of the programs we have been funding demonstrations and we believe it is now time for the local communities to pick up the ongoing support. Second, it reflects our judgment that the Federal Government, in this time of economic crisis, needs to carefully consider all its funding priorities. And in this case, we believe the States are in a relatively better position to assume more of the responsibility for funding.

HELPING GRANTEES TO OBTAIN THIRD-PARTY REIMBURSEMENTS

Mr. CONTE. I have seen reports that HEW will assist affected grantees in recovering third-party reimbursement for services covered under medicare, medicaid, and private health insurance. Would you explain this?

Secretary WEINBERGER. We don't directly assist the grantee by helping him to actually bill the carriers. What we are doing is to help them set up their financial systems and procedures so that they can claim benefits, explaining to them what benefits can be claimed, eligibility criteria, and the like.

I think that these efforts have had a significant payoff. In the community health centers, for example, reimbursements are expected to go up from $18 million in 1974 to $62 million in 1976. Also as a result of our providing technical assistance, we have been able to help the

grantees improve their operating efficiency and reduce their overall costs by something like $40 in the annual per patient cost.

MEDICARE

Mr. CONTE. The 1974 report of the trustees of the hospital insurance trust fund concluded that the present financing schedule for the medicare program was "actuarially adequate" to meet program requirements for the next 25 years. Can you explain what has changed since then to provoke you into proposing reductions in medicare hospital insurance benefits in the 1976 budget?

Secretary WEINBERGER. The actuarial status of the medicare trust fund was not the issue considered in the development of our medicare proposal.

The primary reason for the proposed change is to introduce cost-consiciousness into the beneficiaries' utilization of services while, at the same time, protecting the beneficiary against the high costs of severe long-term illness. This 10 percent coinsurance on services covered under the hospital insurance program will act as a disincentive to unnecessary utilization and the $750 maximum liability per benefit period will protect the beneficiary against the financial drain of an illness by limiting the patient's total payments when he is in an institution for a long stay. Also, I would like to point out that the elderly poor would be protected because medicaid will provide coverage for the 10 percent payment for those individuals eligible for medicaid.

MEDICAID

Mr. CONTE. Mr. Secretary, the Congress has received legislative proposals to reduce the minimum Federal matching grant for medicaid. My own State of Sassachusetts is one which would have it Federal share reduced. It so happens that Massachusetts has been one of the States hardest hit by the recession, with unemployment significantly above the national average. On what grounds do you propose to shift a greater medicaid burden to the States, when they are becoming increasingly unable to meet their prior obligations, much less assume new ones?

Secretary WEINBERGER. In the case of medicaid proposal, the current matching rate is determined on the basis of the relative wealth of the State, with the poorest States receiving up to 78 percent. But, the wealthiest States never receive less than 50 percent. If formula operated on a pure sliding scale, Massachusetts, for example, would be matched at about 46 percent. There are 12 other States like Massachusetts which receive a windfall, in effect, because of the 50 percent minimum matching rate. Reducing the matching rate floor to 40 percent will eliminate some of the inequities in the current matching rates calculations; and, under this formula change your State would be matched at the 46 percent figure.

BUDGET CUTS

Mr. CONTE. You said in your statement that the 1976 budget provides for an increase of $30 million over the revised 1975 budget for human development programs. But isn't that actually $41 million below the

1975 appropriations level? In a period of worsening economic conditions, how can you justify any decrease in the level of service which the Congress felt was necessary last year?

Secretary WEINBERGER. Your comparisons are correct; but, I do not agree with your assessment. We have asked the Congress in the revised 1975 budget to provide the same level of funding for aging and rehabilitation services at the same funding level as 1974. The 1976 budget would continue level funding for these services plus provide increases for Head Start.

CHILD ABUSE

Mr. CONTE. You say that you are going to maintain the activities of the newly established child abuse programs undertaken in 1975, a proposal which I heartily endorse. I am curious, however, about how you intend to maintain the program when your request for child abuse is at the 1975 level. In a period of rapid inflation, isn't it necessary to increase expenditures from year to year in order to maintain the same level of service?

Secretary WEINBERGER. We are requesting nearly $19 million for child abuse in 1976, an increase of $5 million, which should more than maintain a level program.

HANDICAPPED

Mr. CONTE. You say that you are going to concentrate resources on the severely handicapped in the rehabilitation programs, and provide more assistance for training support for students in the rehabilitation field. Again, I applaud your intention, but would like to know how you will do this when your rehabilitation services request is $23 million below the 1975 appropriation?

Secretary WEINBERGER. We are proposing over $730 million for rehabilitation services in the human development account, the same level as 1974 and the level that the program is currently operating at. Second, Mr. Conte, nearly $160 million more in rehabilitation service payments go for the same purposes as in OHD from social security programs—which I might add is an increase of over $25 million. This, I think, represents a substantial and significant commitment.

Mr. CONTE. You are proposing a decline in the numbers of handicapped persons served by your rehabilitation services program. Why this decline? Can you honestly say that the demand for such services is declining?

Secretary WEINBERGER. The decline in the number of handicapped individuals served is the result of the recent legislation which requires emphasis on serving the severely handicapped. Our experience in providing services to the severely handicapped has shown that the cost of rehabilitation is about twice as great as for non-severely handicapped individuals, and that significantly longer time must be spent on serving each severely handicapped individual. This concentration on serving persons with severe handicaps will reduce slightly the number of individuals served in 1976.

SOCIAL SERVICES

Mr. CONTE. You are proposing to reduce Federal spending for social services by some $400 million for the 1975 level, presumably shifting

the burden to the States. First of all, won't there be an increased demand for social service type programs as unemployment and inflation exact their toll on our people? And second, what evidence do you have the States are capable of assuming this burden?

Secretary WEINBERGER. No, Mr. Conte, I do not believe that there is much correlation between the demand for social services and levels of unemployment. The pressures on the welfare system that occur as a result of increased unemployment are on the income assistance side—AFDC, food stamps, medicaid, unemployment benefits, and other forms of cash assistance.

The social services proposal itself is to reduce the current 75 percent Federal matching rate to 65 percent in 1976 and 50 percent in 1977, in order to bring the formula more in line with the direct cash and medical assistance activities. This will require the States to finance more of the costs of the program if they continue all of the services currently being provided. It will also require States to make some of the same hard choices we have had to make. We cannot keep on doing everything. When you have a choice, some things do not get chosen.

QUALITY CONTROL

Mr. CONTE. Mr. Secretary, in your last appearance before this committee, you stated that a new system of quality control standards was being imposed on the AFDC program. You expected to achieve your quality control goal by the end of fiscal year 1975. Would you give us a progress report on your efforts in this area?

Secretary WEINBERGER. Our goal in quality control is to have States reduce their error rates to 3 percent for ineligibility and 5 percent for overpayments and underpayments by June 30, 1975. Based on the progress made by the States in reducing the error rate during the last 6 months of 1974—I think that the preliminary numbers showed that one half of the States achieved their error rate goals—we are optimistic that most of the States will achieve the June 30, 1975 goal.

FOOD STAMPS

Mr. CONTE. There have been some proposals among some Members of Congress to move the food stamp program out of the Agriculture Department and into HEW with the other types of assistance programs. Would you support such a move?

Secretary WEINBERGER. As I indicated earlier to the chairman when you were out of the room, I would not support the transfer of the food stamp program to HEW as it is now constituted. In the meantime, however, planning is going on to find ways to rationalize and simplify all the various Federal income assistance and supplementation programs.

AFDC PAYMENTS

Mr. CONTE. Although there is a cost of living increase ceiling proposed which would hit the neediest of our citizens, the SSI recipients, there is no such ceiling proposed on the AFDC program. Why not? Isn't this inconsistent?

Secretary WEINBERGER. Benefit levels in AFDC are not tied to the CPI as in the case with the supplemental security income program. Each State individually determines the benefit level. Last year for example, I think, that the average benefit increased by about 11 percent and as I recall, the 1976 increase is expected to grow about 7 percent. The President, however, has requested that the non-Federal sector also limit increases to the 5 percent standard proposed for Federal salaries, social security benefits and the SSI program.

CHILD NUTRITION

Mr. CONTE. You are proposing an overall decrease in Federal funding for child nutrition. What programs are you eliminating and why?

Secretary WEINBERGER. I am not sure what you are referring to as HEW does not have programs specifically directed toward the nutrition of children. That is the responsibility of the Department of Agriculture. There is a proposal there that I am aware of that would replace existing child nutrition programs with a new bloc grant but, there would be no decrease in funding as far as I know.

The only specific thing that I can think of in HEW is the nutrition and health programs which is an education program in ESEA. No specific funds are requested in 1976 here because this program was consolidated with several other educational support activities, also with a total higher funding level.

PROGRAMS FOR THE ELDERLY

Mr. CONTE. You are proposing a $25 million cut from the 1975 appropriations for nutrition programs for the elderly, the title VII nutrition program. This program has operated terrifically in my district, and I would like to know why you are proposing this cutback.

Secretary WEINBERGER. Mr. Conte, I would point out once again that we are proposing to maintain the same funding level that the program is current operating. While food costs are going up, improved management, completion of one-time nonrecurring capital expenditures, drawing in other public and private resources, and utilizing food commodities donated by the Department of Agriculture will offset price increases and will enable the Department to continue serving approximately 200,000 meals per day, 5 days per week.

Mr. CONTE. Why are you proposing such a large cutback in research and training programs for the aging—a 50-percent decrease from the 1975 appropriation?

Secretary WEINBERGER. No reductions are proposed in research. The decrease is in the training activity where we are requesting no funds in 1976. We just don't believe that is necessary for the Federal Government to provide training funds in order to assure that there will be an adequate supply of qualified manpower.

STUDENT LOAN DEFAULTS

Mr. CONTE. What is the total amount of student loan defaults to date?

Secretary WEINBERGER. As of January 30, cumulative defaults totaled $80 million. Of this amount, $57 million is for loans directly insured by the Federal Government and the balance of $23 million is for loans insured by the State and private agencies and reinsured by the Federal Government.

Mr. CONTE. Last year you stated that the default rate for student loans had risen from about 5 to 8 percent. This year the rate is 18 percent, and apparently rising. What is being done to lower the default rate?

You stated last year that efforts were made to increase collections on defaulted student loans. Has any effort been made to prevent defaults?

Secretary WEINBERGER. We have three major efforts underway to reduce the default rate and prevent defaults. First of all, we published regulations in final form on February 20, which provide procedures for limiting, suspending, or terminating schools and lenders which have high default rates or otherwise abuse the program. They also include standards for refund policies so that students are protected if they do not complete a course or the school fails on its part. The failure of schools to provide refunds, when due, has led many students to feel cheated and to go into default. Second, we transmitted a legislative proposal to Congress on February 27—two major provisions of which would prohibit proprietary schools from being school lenders and which exclude student loans from bankruptcy for 5 years after leaving school. Third, we have significantly increased our collection activities and we believe this is having a deterrent effect on future defaults. To further our efforts in this area we are requesting an increase of 117 positions.

Mr. CONTE. Has the Office of Education completed a profile on student loan defaulters? Does this give any clue as to how best to prevent defaults?

Secretary WEINBERGER. Yes; the Office of Education has done some work here and it appears from the data that the most significant factor influencing defaults is the type of institution attended. The sample showed that over 75 percent of the defaults in the Federal program were generated by students attending specialized and vocational schools. As I have already mentioned, we have regulations in effect to limit, suspend, or terminate schools which abuse the program. We have also requested authority to eliminate schools as lenders.

PRIVATE EDUCATION

Mr. CONTE. Private educational institutions across the country are in serious financial trouble. Yet again this year you recommend a lower priority for institutional aid. How do you propose to prevent a rash of closings of private educational institutions?

Secretary WEINBERGER. I don't believe that Federal aid, per se, is the answer to the financial troubles of educational institutions, either private or public. Furthermore, the institutional aid programs which HEW has funded do not address school financial problems.

I should also like to point out that one of the major problems causing financial difficulty is the fact that enrollment is down and the school budgets are still geared to the enrollment levels that existed

several years ago when the postwar baby boom hit the colleges. Our basic opportunity grants program is a major effort directed toward recruiting new students to college.

OVERHEAD IN EDUCATION PROGRAMS

Mr. CONTE. The administration has maintained in the past that individual education assistance should be stressed over institutional aid because of the amount of overhead associated with institutional aid. What is the overhead associated with the individual assistance programs, including the amount lost due to student loan defaults? How does this compare with the overhead for institutional aid?

Secretary WEINBERGER. I think there is some confusion over the use of the term overhead. We have never advanced the argument that student aid is preferable to institutional aid because of the amount of overhead associated with institutional aid. Our point is that student aid has an advantage over institutional aid because it allows the student greater choice in pursuing the type of education that best suits his need.

STUDENT AID PROGRAMS

Mr. CONTE. Does the basic educational opportunity grant program still require individuals to provide a copy of their tax return at the time the application is made? What other alternatives for determining assets could be used?

Secretary WEINBERGER. The basic educational opportunity grant program has never required that the income tax return be submitted with the application. The Office of Education has asked that certain figures be extracted from certain lines on the income tax form to assure uniformity in the answers to these questions. No information is requested from the income tax return concerning assets. Applicants are asked to list the market value of such assets as land and houses.

Mr. CONTE. What is the maximum amount of education assistance available to a student under the various Federal programs.

Secretary WEINBERGER. It is possible for a student to receive Federal assistance for the total cost of his education through a combination of Federal educational assistance programs. However, assistance is limited to the actual amount of money needed to complete the educational program. For example, a student may receive a basic educational opportunity grant for up to one-half the cost of his educational program and a guaranteed student loan for the remainder; or he may earn money under the work-study program, receive a basic grant, and receive a federally supported State scholarship, supplemental grant, or direct loan.

Mr. CONTE. Why is the administration again seeking to reduce funding for the work-study program?

Secretary WEINBERGER. We are seeking $250 million for that program. There is a reduction in that activity from the 1976 appropriation, but it is more than made up by nearly $400 million in increase in the basic opportunity grants program.

REVENUE SHARING

Mr. CONTE. Testimony before this subcommittee last year indicated that State and local governments had used approximately 24 percent

of their general revenue sharing moneys for education. Has this increased or decreased?

Secretary WEINBERGER. I believe that the use of general revenue sharing funds for education has remained approximately the same. As I recall, Treasury's last report showed a figure of about 22 percent.

BILINGUAL EDUCATION

Mr. CONTE. The Supreme Court in *Lau* v. *Nichols* mandates increased bilingual learning opportunities for children from families whose primary language is other than English. The fiscal year 1976 budget, however, recommends a decrease in budget authority for bilingual programs. Why isn't more of an effort being made to comply with the Court's decision?

Secretary WEINBERGER. First of all, compliance with that decision is a State and local responsibility. The bilingual education program administered by the Office of Education is essentially a demonstration and technical assistance program which is designed to help the States and school districts carry out their bilingual programs. And we are proposing $70 million in 1976, the same amount as in the President's revised 1975 request.

EDUCATION FOR THE HANDICAPPED

Mr. CONTE. There are indications that over 40 percent of the handicapped children in this country are not receiving the educational services they need to prepare themselves to take a place in society. The administration proposes no funding increase in programs to assist the handicapped for fiscal year 1974–76. Recent court decisions and State laws have required more effort be made to assist the handicapped. Why is this not given a higher priority at HEW?

Secretary WEINBERGER. It is a high priority and the 1976 budget requests increases totaling more than $25 million for teacher training, research, and demonstration programs designed to increase the capacity of State and local educational agencies to provide a high quality of service. The basic responsibility for providing the services, though, is a State and local one.

LIBRARIES

Mr. CONTE. You propose a substantial reduction in library assistance programs. Testimony before this subcommittee during consideration of the supplemental appropriations request last year indicated that 20 percent of the population are not served by a library. What efforts are being made to fill this need?

Secretary WEINBERGER. The figures I have heard are that well over 90 percent of the population has access to some form of public library service and we believe that the need for continued Federal support is no longer required. The statistics indicate to me that the Federal Government has been more than successful in acting as a catalyst for the extension of library services and that it is now up to the States and localities to continue the efforts. We view our role now as one of improving the utilization of libraries and achieving greater efficiency of operations through the sharing of library resources and other ways.

This is the thrust of the new library partnership legislation we have proposed.

VETERANS COST OF INSTRUCTION PROGRAM

Mr. CONTE. The administration is again proposing termination of the veterans cost of instruction program, saying "the high point of the need has passed." February's unemployment figures show that veterans aged 20 to 24 have an unemployment rate of 19.7 percent. The veterans cost of instruction program is designed to recruit veterans. Wouldn't continuation of this program remove some of the strain from the labor market?

Secretary WEINBERGER. We do not believe that the cost of instruction program needs to be continued in order to assure successful recruitment of veterans to college. In the first place it duplicates services provided by the Veterans' Administration and, second, it provides no financial aid to the veteran, and it is level of benefits received by him which determines whether he can go to college or not. With the recent rate increases, the Veterans' Administration educational benefits are a significant incentive to go on to college, especially if he is unemployed—I believe that the basic benefit is around $270 per month for the unmarried veteran. And if he is married he receives additional benefits. Furthermore, the veteran is also eligible for OE's student aid programs-basic opportunity grants, work study, and guaranteed loans.

COST REDUCTIONS

Mr. CONTE. The fiscal year 1976 HEW budget request, and your statement this morning, stress the need to bring Federal spending under control. You propose a ceiling of 5 percent on social security cost-of-living increases. It is becoming increasingly evident that the Congress will not go along with such a request, and I suspect this was realized when the budget was finalized. What is HEW recommending to reduce its own costs?

Secretary WEINBERGER. During fiscal year 1975 we made a special review of administrative expenses throughout the Department and are now in the process of implementing about a $100 million reduction in our operating expenses. This lowered base forms the starting point for our request for administrative expenses in 1976 and we will continue to explore ways of further economizing in our own operations.

Mr. CONTE. The fiscal year 1976 HEW budget would also place greater reliance upon State governments in financing various assistance programs. What indications do you have that the States are able to shoulder these added burdens?

Secretary WEINBERGER. Our proposal to have the States carry a larger share of the burden of public assistance and other programs is based on the perception that the States are in a relatively better financial condition than the Federal Government is. Although we recognize that States are facing serious problems, we believe that even within the budget constraints now faced by the States, the programs of cash and medical aid to the poor could receive a higher relative priority in making claims for State funding.

I would also note that the SSI programs permitted the States to shift to the Federal Government a large share of the financial burden

for providing welfare benefits to the aged and disabled. Finally the extra funds provided through general revenue sharing have permitted most States and localities to either reduce taxes or avoid imposing new taxes. These sources of revenue may now need to be tapped.

Mr. CONTE. What has been the effect of increased decentralization on HEW's overhead?

Secretary WEINBERGER. This is really a hard question to answer since we really haven't done much decentralization, because of congressional opposition to our plans. Where decentralization has occurred it has not had any significant impact on overhead.

Mr. CONTE. What savings do you anticipate from grant consolidation? How are these savings reflected in the fiscal year 1976 budget?

Secretary WEINBERGER. The savings would accrue to the States and show up as improved effectiveness in the programs aided by Federal dollars. We believe that the States will use the consolidation in education to develop an allocation of Federal aid which meets their needs more effectively than was possible under the categorical approach. We have not proposed any reduction in our budget because of this. We believe that the States should be able to take advantage of this flexibility without any fiscal penalty.

The consolidation will, however, reduce the administrative costs of the Office of Education. We proposed in the regular budget for 1975 a reduction of some 200 positions in the Office of Education related to consolidation proposals.

Mr. CONTE. In testimony before this subcommittee last year, you indicated concern over HEW staffing levels and stated that you were initiating a thorough review of HEW manpower allocations. Has this review been completed? What savings have been realized as a result of the review?

Secretary WEINBERGER. A system has been set up for the review of each agency's total staffing level over the next several years. We make periodic reports on our progress to the President. I believe that our review of the manpower requirements for the fiscal year 1976 budget were more systematic than in past budgets but we still have a long way to go to do the job the way it really should be done.

NATIONAL INSTITUTE OF EDUCATION

Mr. CONTE. To what extent does the National Institute of Education duplicate other research and development programs in education?

Secretary WEINBERGER. Although the authorizing legislation is sufficiently broad so that there could be overlap between the Office of Education and the National Institute of Education, I do not think that there is any significant duplication in practice. NIE and OE have an understanding on what the proper division of labor should be. This kind of regular working relationship should minimize the problem of duplication.

Mr. CONTE. The fiscal year 1976 budget recommends cutbacks in many programs, yet proposes increases for educational R. & D. What is the rationale for limiting programs providing direct assistance to individuals and institutions while increasing research and development funding? Couldn't R. & D. wait until the economic picture brightens?

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Secretary WEINBERGER. The increase we are proposing for NIE is only $10 million, bringing the total $80 million from the fiscal year 1976 budget. I would note that this is about one-half of the funding level that we requested from Congress when NIE was first authorized. Because of the potential long-range benefits, I think that further delay in moving forward in educational research would be unwise. With regard to direct assistance to individuals, I would note that almost all of the $8 billion increase in outlays proposed for HEW in 1976 would go to aid individuals, including social security retirees, medicare beneficiaries, and people on public assistance and SSI.

MONITORING GRANTS AND CONTRACTS

Mr. CONTE. Last year you indicated concern over the monitoring efforts for some 43,000 grants and 23,000 contracts. You stated that 9,000 grants and contracts had been lost. Has the Department been able to improve monitoring over the past year? What efforts will be made in this area in the coming year?

Secretary WEINBERGER. We have strengthened grant and contract monitoring by bringing together all related policy and review functions in this area into a single office under the Assistant Secretary for Administration and Management. During the last year this group issued a complete revision of the grants administration manual and has been providing technical assistance and training for all of the Department's contracting and procurement officers. Right now they are in the process of implementing a Department-wide contract information system which should be in full operation by July 1, 1975. I think we are making real progress in remedying the grants and contract situation.

TERMINATION OF ADVISORY COMMITTEES

Mr. CONTE. Last year you reported some success in terminating unnecessary advisory committees. How many advisory committees have been terminated over the past year? How many remain? Have you made recommendations to the Congress regarding those committees established by the Congress?

Secretary WEINBERGER. During my first year as Secretary, we reduced the number of advisory committees by 72. During the last year we terminated 28 committees established 23 new committees and eight more which were mandated by law.

We have asked Congress on several occasions to discontinue or consolidate advisory committees. Thus far we have not been very successful. In fact, some legislation, such as the new research training authority, establishes new advisory committees which we did not ask for.

MEDICARE ABUSES

Mr. CONTE. Mr. Secretary, I have seen accounts the HEW follows up on less than 1 percent of the thousands of allegations regarding illegal medicare reimbursements which are reported annually. Is this true, and if so, don't you think that more stringent investigation might be in order?

Secretary WEINBERGER. I don't believe that is the case. My recollection is that SSA reviews and investigates thousands of allegations each year. The 1 percent figure refers to the number of cases which the Department has reviewed and turns over to the Justice Department for prosecution. The rest of them can be cleared up without prosecution.

Mr. CONTE. Thank you.

Mr. FLOOD. Thank you, Mr. Secretary. I couldn't have done better myself.

Secretary WEINBERGER. Thank you, Mr. Chairman.

Mr. FLOOD. We will put in the record a number of special reports which pull together the Department's activities in various fields, such as aging, mental retardation, day care, family planning, and so on.

[The reports follow:]

SPECIAL REPORTS

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ALCOHOLISM

Obligations for Programs in Alcoholism
(In thousands of dollars)

	1972	1973	1974	1975 Estimate	1976 Estimate
Public Health Service:					
Alcohol, Drug Abuse, and Mental Health Administration					
National Institute on Alcohol Abuse and Alcoholism					
Obligations	$86,735	$76,314	$199,975	$110,090	$114,199
Center for Disease Control.	41	---	---	---	---
Health Services Administration					
Indian Health Services...	1/	1/	1/	1/	1/
National Institutes of Health					
National Institute of Arthritis, Metabolism, and Digestive Diseases	1/	1/	1/	1/	1/
Subtotal, Public Health Service	86,776	76,314	199,975	110,090	114,199
Social and Rehabilitation Service:					
Community Services Administration:					
Social Services	1/	24,988	26,500	30,500	35,000
Office of Human Development:					
Rehabilitation Services Administration:					
Basic State grants	26,880	29,450	25,830	27,200	27,200
Expansion grants	360 2/	360	386	---	---
Facility improvement	60	51	34	35	31
Rehabilitation training	20	48	---	---	---
Rehabilitation research and demonstrations	---	---	---	100	100
Subtotal	27,320	29,909	26,250	27,335	27,331
Total	114,096	131,211	252,725	167,925	176,530

1/ Obligations not identifiable.
2/ Excludes $1,000,000 transferred from National Institute on Alcohol Abuse and Alcoholism.

SPECIAL REPORT - ALCOHOLISM

THE SCOPE OF THE PROBLEM

Alcoholism and alcohol abuse is one of our most serious health problems. Although the use of alcoholic beverages is harmless to most people and apparently beneficial for some, alcoholism is an illness that plagues at least 9 million Americans directly, and many times that number when one considers the effects on families and others. It is an illness that can engender other serious diseases--such as cardiomyopathy, cancer, cirrhosis--and can shorten the life-span of its victims by many years. Alcoholism and alcohol abuse continue to occur at high incidence rates within the American society. And yet, it did not become a national health priority until a few years ago.

Alcoholism or problem drinking today afflicts an estimated 9 million Americans whose drinking has created some problem for themselves, their families, their friends, employers, or police. Alcohol-related problems are the cause of deaths in the United States each year. An estimated 2 1/2 million arrests every year are related to alcohol. Alcoholism shortens life expectancy 10 to 12 years. Approximately 35,000 accidental deaths at home, work, or recreation involve abuse of alcohol. One-third of all deaths reported as suicide and one-half of all homicides are alcohol-related. To these statistics must be added immeasurable human costs and suffering--broken homes, deserted families, and psychological problems--resulting from alcohol abuse and alcoholism. Acoholism affects the lives of some 36 million persons in the United States.

In the past, alcoholism was considered mainly a moral or judicial problem. In recent years, however, alcoholism has become recognized as an illness, and alcoholism and alcohol abuse as major public health problems in our society. Because of the tremendous overlap among complicated social, psychological, physical, and cultural factors associated with the nature and development of these problems, a wide-ranging program is necessary for a better understanding of alcohol, its abuse, and alcoholism in our culture and society, and to integrate help for these problems into routine provision of health and social services.

The proportion of American youth who drink has been increasing so that currently it is almost universal. The highest scores on an index of possible problem-drinking behaviors were recorded in the youngest age group for which data are available, the 18-20 year olds. The public suffers from much ignorance concerning alcohol and from ambivalent feelings toward it. Worse yet, heavier drinkers know less about alcohol than do lighter drinkers or abstainers. The economic cost associated with misuse of alcohol is estimated at $25 billion a year. Of this total, $9.4 billion is attributable to lost production, $6.4 billion to motor vehicle accidents, $8.3 billion to alcohol related health and medical problems, $0.64 billion to costs specifically directed towards diagnosis, treatment, rehabilitation, prevention, and education in the alcohol field, $0.51 billion to criminal justice system's components - police, courts, and correctional institutions (as a result of both violent and anti-social behavior which was linked to alcohol abuse and alcoholism), and $0.14 billion to social services program costs.

Experiences and document reports have shown that alcohol is the most abused drug among adults and teenagers in this country. About 5 percent of the nation's work force are alcoholic individuals, while almost another 5 percent are serious alcohol abusers. Although the most visible victims of alcoholism are inhabitants of skid rows across the nation, they represent only 3 to 5 percent of the alcoholic population. Public intoxication, however, usually involving skid row inhabitants, accounts for 50 percent or over one million of all arrests reported annually, including arrests for traffic violations.

Among American Indians, alcoholism is at an epidemic level. The rate is at least 10 percent, or twice as high as the national average. On some American Indian reservations the rate runs from 25 to 50 percent.

Alcohol abuse and alcoholism are recognized as major health problems in most developed and many developing nations, but despite the virtual universality of the problems, there has been very little multinational collaboration in developing more effective methods to combat them.

Alcohol problems viewed from any perspective cause grievous pain: hurt to the afflicted person, his family, and society. As an illness, alcoholism is devastating; the source of accidents and poor health; a contributor to the disruption of families, a well of human misery.

PUBLIC HEALTH SERVICE
Alcohol Drug Abuse, and Mental Health Administration
National Institute on Alcohol Abuse and Alcoholism

Among the many interesting developments in the field of alcoholism during the past 4 years, perhaps the most significant event has been the wide-ranging commitment of the Federal government to the problems of alcohol abuse and alcoholism.

The National Institute on Alcohol Abuse and Alcoholis, created by an Act of the United States Congress (Public Law 91-616), was formally established in May 1971. The Institute develops and supports programs to (1) improve treatment services for alcoholic persons in States and communities, (2) treat and rehabilitate employees with drinking problems in Government and private industry, (3) modify public attitudes toward alcoholism and alcohol-related problems by developing a program of education and public information, (4) train professional and non-professional personnel, and (5) determine through research the causes and prevention of alcoholism and alcohol abuse. The Institute is rapidly developing a coordinated national alcoholism program. As a step toward the accomplishment of this goal, the National Institute on Alcohol Abuse and Alcoholism is providing funds for the development of adequate treatment services for alcoholic persons, based, whenever possible, on existing services.

Fiscal year 1972 was the Institute's first full year of operations, a year of dynamic growth and challenge. Throughout the country, along with the expansion of programs initiated in FY 1971, new programs for alcoholic people were developed such as those for public inebriates and the alcoholism poverty program.

During FY 1973 the Institute moved substantially closer to its primary goal of making effective treatment available at the local level to every alcoholic person in the United States. The development of alternative fiscal resources was also stimulated in order to expand services and make projects more financially independent. Further, recognizing that no illness has ever been eradicated by just treating the casualties, the Institute made a sound beginning towards the long-range goal of prevention. Sophisticated educational and informational techniques were initiated to foster the concept of responsible alcohol use among those who choose to drink.

During Fiscal Year 1974, the Institute continued to foster the development of community-based resources for alcoholism treatment. The alcoholism field in general continued its significant growth at State and local levels in response to the awareness and momentum generated by the Federal leadership. The NIAAA leadership role was enhanced by its placement as a separate Institute within the new Alcohol, Drug Abuse, and Mental Health Administration. In FY 74, the Institute also began

more intensive enlistment of the Nation's private enterprise system to the Nation's alcoholism effort. NIAAA initiated programs to foster the development of guidelines for counselor certification and alcoholism program accreditation as an important step towards generating greater third-party payments for treatment services. An increasing number of private companies initiated occupational alcoholism programs for their employees. In the prevention area, the NIAAA's National Center for Alcohol Education began operations, and the need to respond to increasing public awareness sparked a significant expansion in the activities of the National Clearinghouse for Alcohol Information. Near the end of the Fiscal Year, the program authorities of the NIAAA were renewed and expanded by the passage of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act Amendments of 1974 (P.L. 93-282).

The Federal resources administered by the NIAAA reaches States, communities, and individuals through the activities of four operating Divisions: State and Community Assistance Programs, Special Treatment and Rehabilitation Programs, Prevention, and Research.

DIVISION OF STATE AND COMMUNITY ASSISTANCE PROGRAMS

The Division of State and Community Assistance Programs provides technical and financial support to community organizations seeking facilities to provide alcoholism treatment and rehabilitation services.

State Assistance Branch

State Alcoholism Formula funds were awarded at the end of Fiscal Year 1974 and became available to the 50 States, the District of Columbia and Puerto Rico, for utilization for two years, and to the Virgin Islands, Guam, American Samoa, and the Trust Territories of the Pacific Islands, for three years.

Programs operational in Fiscal Year 1973 continued to expand during 1974. The results of studies previously initiated and the evaluation of the ongoing programs within the States were used in updating the Plans. In many cases the findings necessitated the changing or reordering of priorities. For example, public awareness programs and organization of local groups were so effective that the State Authorities were flooded with applications for community services. Since the demand was so great, ranking and reordering of priorities became a necessity.

In February 1974, $30 million of Fiscal Year 1973 appropriated funds were released for distribution.

Since the formula grant program is decentralized, these funds were transferred to the Regional Offices for distribution.

Meetings were conducted in the Regional Offices which involved State personnel administering plans as well as regional staff and alcohol consultants. Mutual problems were discussed and the State personnel were better oriented to national and Regional objectives as well as legislative changes. Review, approval, and awarding functions continued as a Regional activity. As updated plans arrived, Central Office staff were called upon to participate as review members or to submit comments and recommendations to those regions not using the more formalized review approach. $45.6 million was awarded in regular formula grants during Fiscal Year 1974. Therefore, a total of $75.6 million was obligated in Fiscal Year 1974 which includes the $30 million in released funds.

During the year, the State Alcoholism Authorities felt the need for an organization to deal collectively with their common problems. Incorporation documents were filed in the District of Columbia and the organization known as the Council of State and Territorial Alcohol Authorities was formed. The Council is currently recruiting for an Executive Director and other personnel.

The 1974 alcoholism amendments, P.L. 93-282, which were signed into Law May 14, 1974, include special grants for implementation of the Uniform Alcoholism and Intoxication Treatment Act. States which have enacted the basic provisions of this Act were eligible to receive $100,000 plus 10% of their formula allotment. Work began immediately to develop the regulations and guidelines for this program and it is expected they will be published early in Fiscal Year 1975.

DIVISION OF SPECIAL TREATMENT AND REHABILITATION PROGRAMS

The Division of Special Treatment and Rehabilitation Programs was engaged in developing and supporting programs to reduce and prevent alcohol-related problems with particular emphasis on the needs of special population groups. Among the collaborative programs established were those providing treatment services designed for alcoholic employees of goverment and industry, staffing and cross-populations, low-income persons, American Indians, Alaskan natives, Blacks, Spanish-Americans, the criminal justice population, women, youth, migrant farm laborers, chronic drunkenness offenders and drinking drivers. The Division is comprised of an Occupational Alcoholism Branch and a Special Projects Branch.

Occupational Alcoholism Branch

In accordance with the intent of Congress and the requirements of the Secretary of HEW under the provisions of Title II, Public Law 91-616 and Title V, Public Law 92-129, Section 501, the Occupational Alcoholism Branch has supported on a national scale major efforts to develop and implement program activities designed to meet the alcohol abuse and alcoholism treatment needs of the employed populations and the Armed Forces for whom this Branch provided consultative support in the creation and evaluation of their programs for the treatment of alcoholic members.

Commencing in FY 1972, the Occupational Alcoholism Branch, in accordance with its concepts and philosophy, encouraged employers -- Federal, State, and local governments, private industry, and the Armed Forces -- to adopt "the troubled employee" approach to identify for treatment purposes those employees whose job performance was being impaired through their use of alcohol. This approach was embraced after study of the problems encountered in the implementation of early industrial alcoholism programs and a survey of existing programs. Support for the troubled employee approach met with resistance from the traditional industrial alcohologists. However, a survey of all state programs clearly revealed that "troubled employee" programs were the type more likely to be advocated by the State Occupational Program Consultants. Additionally, whereas older industrial alcoholism programs tend to be in larger companies, the survey revealed that State Occupational Program Consultants are now dealing with both smaller businesses and with organizations at the local level.

The Occupational Alcoholism Program consists of three types of projects: (1) State Occupational Alcoholism Consultant Projects; (2) Programs for Federal Employees; and (3) Industrial Alcoholism Projects.

Occupational State and Territorial Consultant Program Grants

In FY 1974, State Occupational Grants provided each of 49 States, the District of Columbia, Puerto Rico and the Virgin Islands, with two trained occupational consultants. They were qualified to create programs of management control systems for business, industry, and State and local government in cooperation with management and employee organizations.

In January 1974, an 18-month continuing education program for occupational program consultants employed by the States and sponsored by grant funds from the Institute was concluded. To advance the training of Occupational Consultants at the State, Regional and Local levels, a contract was awarded in April 1974 to an educational institution to support training for personnel now employed in the 52 State and Territorial Programs through June 1975.

To determine the impetus generated in the private and public sectors as a result of State Occupational Alcoholism efforts, an updated survey was undertaken. Tentative statistical data on 18 states at the time of this input indicated:

- 121 new private company programs with substantiated policy statements
- 43 new public programs including 11 state policies

Programs for Federal Employees

While the Civil Service Commission (under Public Law 91-616) is responsible for developing programs in civilian agencies in cooperation with those agencies, NIAAA provided, on request, technical consultative assistance to the Commission and to individual agencies.

The Occupational Alcoholism Branch fulfilled its mandate by assisting in the development of programs through providing consultation from a cadre of experts drawn from around the country to Civil Service personnel and to Federal department facilities, wherever located. This responsiveness has extended to components of the Department of Defense.

Industrial Program Grants

Industrial Alcoholism Project Grants were funded and aimed at the development of services within the industrial environment capable of reaching the employed problem drinker early in the course of his illness. The program seeked to establish new methods of effective case-finding, referral systems and industry-union-community relationships to facilitate the provision of services to alcoholic employees. During FY 1974, a total of 21 project grants were awarded.

In FY 1974, a total of 78 occupational grants, including the 21 industrial program grants, were awarded in the amount of $6,536,193 for 49 States, the District of Columbia, Puerto Rico and the Virgin Islands.

Special Projects Branch

The Special Projects Branch has two thrusts: (1) the Staffing and Cross-Population programs, the Poverty Programs, and the Special Population Programs - American Indians, Alaskan Natives, Black, Spanish-Americans, Women, Youth, Migrant Farm Laborers; and (2) the Alcohol and Public Safety Programs including the Drinking Drivers, the Criminal Justice and Public Inebriate Programs.

Staffing and Cross-Population Programs

During FY 1974, staffing grants provided support of program efforts to develop and conduct comprehensive alcoholism treatment and rehabilitation services programs. Funds were made available to support initial salary costs of professional and technical personnel providing alcoholism services. This program is authorized under Part C of the Community Mental Health Centers Act, Public Law 91-211.

The NIAAA has been utilizing the comprehensive staffing grant mechanism to provide funding for such programs. However, this funding mechanism required a specific range of services, including inpatient, outpatient, intermediate, and emergency care as well as consultation and education services, regardless of the total needs of service recipients. In addition, the staffing grant mechanism was limited to the provision of funds for the salaries of professional and technical personnel. It did not provide funds for consultation fees, equipment, travel, etc.

In an effort to be more responsive to the total human needs of service recipients, the NIAAA discontinued the use of the staffing grant mechanism in funding new projects. The direct project grant, which allows funding support for the full operating cost without specific type of service requirements and limitation on the use of consultants, is now being utilized as the funding mechanism for such programs.

The term "Cross-Population Program" was devised as a means of identifying this particular program effort. This term "Cross-Population" is in keeping with the Institute's policy of directing the focus of communities on the needs of alcoholic people rather than the needs of institutions or particular service systems. Cross-Population Projects enable communities, which consist of more than one target population group, to utilize the various guidelines of the Institute that pertain to these special population groups in a flexible manner as determined by the needs of the alcoholic population.

The Institute is continuing its commitment to the presently funded Staffing Grant Programs. During FY 1974, a total of 45 comprehensive staffing programs were supported in the amount of $11,839,943.

Poverty Program

The Community Alcoholism Services Poverty Program is a component of the Special Projects Branch within the Division of Special Treatment and Rehabilitation Programs. This program was initiated officially on May 7, 1972, concurrent with the transfer of the Alcoholism Recovery Projects from the Office of Economic Opportunity to the National Institute on Alcohol Abuse and Alcoholism.

The intent of the program is to support special projects that demonstrate how a variety of services can be made available, and be effectively utilized by the poor alcoholic person and his family. In a broader context, it is intended to demonstrate that the poor can be integrated into existing health and social service systems.

Additionally, a contract between the National Council on Alcoholism (NCA) and the Office of Economic Opportunity to provide technical assistance and monitoring to the service programs was transferred to NIAAA on July 1, 1972, at a cost of $305,629. This contract has been renegotiated for an additional year. The total cost for FY 1974 was $140,746.

During FY 1974, 186 projects were funded at a level of $14,909,705.

The American Indian Program

The Institute has recognized the special severity of alcoholism problems among American Indians and has made support of alcoholism programs for them one of its top priorities. During FY 1974, NIAAA supported 124 Indian alcoholism grants totalling $12,485,873, in both urban and reservation areas.

The primary objective in FY 1974 of the American Indian alcoholism program was to assist in making the best alcoholism treatment and rehabilitation services available at the community level. To accomplish this objective, each program was designed to provide a variety of services which included residential care, including room and board, for problem drinkers who were seeking help--individual counseling, job placement, referral service, group therapy, Indian AA groups, didactic lectures, work therapy, recreation and self-government. Other methods which were utilized to help Indian communities solve their alcohol abuse problems included broad programs of public education, training of Indian people, and development of community services.

Since their inception, the Indian alcoholism programs have had a significant impact upon the attitude of Indian people toward drinking--the first vital step in recovery. The communities and Indian tribes living on reservations have gained valuable knowledge about alcohol abuse and are now viewing alcoholism as a major social, cultural, and economic problem. Other alcoholism programs without Federal funds were developed, and community resources have been organized in a concerted effort to meet the needs of Indian people afflicted by alcoholism. The following are examples of the results achieved in FY 1974 by the alcoholism programs supported by NIAAA:

- 50% of the NIAAA Indian alcoholism program clients recovered and became productive citizens - 10% of these became sober - 40% changed drinking patterns for the better (family relationships did improve).

- 15-20% did obtain jobs through the programs - this was especially important with exceedingly high rates of Indian unemployment.

- The NIAAA programs did encourage Indian persons in Federal, State and local jails, with alcohol problems, to enter into treatment programs after release.

- Approximately 100 Indian Alcoholics Anonymous groups have been established - prior to the NIAAA supported programs Indian people traditionally shunned AA groups.

To assist in carrying out its objectives an Indian Desk was maintained within NIAAA which was staffed by experienced Indian people to monitor, assist, and advise these programs. In addition, the Indian Desk is charged with the responsibility of maintaining close liaison with other Federal agencies involved in health care and social service delivery to Indian people, as well as with national Indian advocate organizations. The NIAAA also employs the American Indian Commission on Alcohol and Drug Abuse (AICADA), a non-profit organization, to provide technical assistance to isolated American Indian communities on and off the reservation. AICADA, located in Arvada, Colorado, has earned the reputation as an organization representative of Indian interests with experience in combating the unique problems associated with alcohol abuse among the American Indians.

Alaskan Native Programs

To parallel the above efforts of NIAAA, a special "mini-grant" program was launched in FY 1973 to provide $5,000 - 10,000, one year project grants to Alaskan Native communities to assist their people in developing their own alternatives to combat alcoholism among the Alaskan Native people. In FY 1973, the NIAAA funded 44 Alaskan Native mini-grants in the amount of $472,826. During FY 1974, 119 additional new mini-grant programs were funded in the amount of $1,179,398.

The overwhelming response of the Alaskan Native people has been to construct, remodel, or rent village centers to serve as focal points for Alaskan Native people in which to engage in a variety of constructive activities such as arts and crafts, youth and adult recreation, repair and sale of small machinery such as snow equipment, employment training, village meetings and AA meetings. The variety of planned activities and equipment is regarded by the Alaskan Native communities as their most urgent need and most effective way to begin helping their people face and overcome their drinking problems.

Programs for Special Population Groups

Many minority groups in our society have experienced exceptional deprivation. For these disadvantaged citizens, heavy drinking has accentuated or been a response to such hardships as a limited access to job opportunities, unequal housing and schooling, and inadequate medical care. In an effort to be responsive to the needs of such population the Institute has placed heavy emphasis on providing funding support to these target populations.

Black Alcoholism Program

An initiative to establish an advocacy group to represent the Black alcoholism constituency has been launched by a group of Black alcoholism program people resulting in the formation of the National Black Council on Alcoholism (NBCA). The goals of the NBCA are: to promote the development of policies and programs responsive to the needs of the Black alcoholism constituency and its service providers; to establish a viable communications network for dissemination of relevant information to Black alcoholism workers; to stimulate the development of Black-oriented alcoholism research; and to identify training needs and develop the mechanism for meeting these needs.

Spanish-American Programs

As a result of the demonstrated need for alcoholism programs to assist this bicultural and bilingual population, the Spanish-American communities organized themselves under the aegis of the National Commission on Spanish-Speaking Alcoholism, Inc. (NCSSA). This group officially incorporated itself on August 30, 1974 in Los Angeles, California, to assist in the establishment, implementation and enhancement of alcoholism programs within the Spanish-Speaking Community.

The NCSSA has requested financial and technical assistance from NIAAA in planning a National Alcoholism Conference for Spanish-Speaking in March 1975 in San Francisco. The main purpose of the Conference will be to provide assistance to community-based organizations in the areas of treatment and rehabilitation, training, prevention, research, and technical assistance in order to insure the establishment, implementation, and enhancement of alcoholism programs within the various Spanish-Speaking communities of the United States and Puerto Rico.

Women's Program

The Institute has initiated and supported projects designed to meet the special treatment and prevention needs of women who suffer from alcohol abuse and alcoholism. Services in these programs were tailored to the full-range of problems which were specifically encountered by women and which manifest themselves in excessive drinking.

Youth Programs

The incidence rate of heavy drinking among young people prompted the Institute to stimulate and support a number of prevention, treatment and rehabilitation programs serving various youth age groups.

Migrant Farmworkers Alcoholism Programs

The migrant and seasonal farmworkers have traditionally.been one of the most neglected special population groups in our country. For those farmworkers who may be experiencing alcoholism problems, their life is made especially difficult because of their dire housing, unemployment and under-employment, poor educational background, poor health care and,in general, the discrimination (racial and otherwise) which a local community may exhibit because of the transient nature of these "intruders" into their towns, cities, and counties.

With the recent energy crisis, the anxiety level of many migrant and seasonal workers has vastly increased. With the increase in the price of gasoline, their domestic travels from one part of the country to another has been curtailed thereby severely limiting their earning power. With no employment, their depression will increase and consequently they will then have an even higher risk alcoholism potential.

The NIAAA has placed great emphasis in FY 1974 on developing alcoholism programs for this group.

Funding of Special Population Programs

Certain special population programs described above which consist of the Cross-population, Blacks, Spanish-Americans, women, youth, migrant farmworkers, and criminal-justice programs (latter described on page 12) were funded under a collective category called "Project Demonstration Grants."

In FY 1974, a total of 81 project demonstration grants were funded in the amount of $21,334,470.

Alcohol and Public Safety Programs

The Drinking Driver, Public Inebriate, and Criminal Justice Alcoholism Projects are the main focus of the Alcohol and Public Safety Program efforts.

Drinking Driver Program

Close collaboration and coordination with the National Highway Traffic Safety Administration has been maintained. Seventeen drinking driver projects have been funded in the amount of $2,923,841. These projects provide drinking driver treatment funds for communities to mount their own drinking driver identification mechanism. This mechanism has provided a unique means of early detection and intervention in dealing with the problem drinker. As the projects were implemented, arrests have increased and alcohol-related accident rates have decreased. More judges and prosecutors became convinced that the interacting system has merits as

it has helped to create cooperative relationships between the courts, law enforcement personnel and the Alcohol Service Program of the communities. The health care system in most communities has benefited by the introduction of a new alcoholism treatment facility and the additional funding provided by the grant mechanism of NIAAA. The community has benefited from the infusion of additional money and personnel into alcoholism programs.

Public Inebriate Program

The general objective of the Public Inebriate Program is the improvement of individuals with a drunkenness problem, particularly those living in the subculture of skid row. For many individuals the goal of improvement is obviously quite limited. Some have been significantly helped to avoid deterioration and others to improve their level of functioning sufficiently that they may live outside of the subculture.

Because of the extreme conditions so often associated with the men and women living in this subculture, the population served has been provided with a twenty-four hour walk-in service. Clients are received with dignity and consideration. Such a service is especially accessible to those who are most ill or debilitated and, therefore, these drop-in centers are all located within walking distance of the skid row area. Its functions have been physical care, diagnosis, screening, referral, some direct treatment and outreach services. More basically, good warm meals have been provided along with showers and clean clothes. Professional outpatient services have included medical care, psychological testing, social services and counseling.

The arrest and incarceration of individuals who are publicly intoxicated have long been an accepted response to the problems of drunkenness. History has demonstrated, however, that such legal response is unlikely to produce any positive changes either in arrested individuals or in the overall problem of public intoxication. Consequently, interest has increased in developing alternatives to criminal prosecution for public inebriates which can reduce the magnitude of the problem and, at the same time, reflect recent court decisions concerning chronic public inebriation.

The existing Public Inebriate Programs in operation during FY 1974 have demonstrated the effectiveness of such programming in the following ways:

1. Reduced the number of public inebriates and improved the health of those remaining in the subculture of skid row.

2. Demonstrated that skid row people are better and more effectively served when treated through a health care system rather than the criminal justice system.

3. Proved that the health care system was a financially feasiable alternative to the criminal justice system in caring for the public inebriate.

4. Evidenced that an intensive inpatient rehabilitation program was effective when provided for the less acculturated, nonhard core skid row person.

5. Proved that the transitional residence was therapeutically advantageous to those clients in that subculture who wish, at least initially, to adhere to the values of skid row.

6. Resulted in the largest public savings from rehabilitation of public inebriates in the criminal justice system.

7. Determined that the criminal justice system could realize substantial annual savings if rehabilitation programs are introduced.

Utilizing Existing Community Resources

New and revised guidelines were established in FY 1974 for Public Inebriate Programs emphasizing the utilization of existing resources. Coordination of the efforts on the part of the treatment service agencies was vitally important to assure continuity of care throughout the course of the individual's treatment.

Every effort was made to achieve the close cooperation and coordination with the police, courts, and other service-providing agencies. The programs have uniformly assured adequate care and prevented the merry-go-round life of the drunkenness offender. Through grant awards to deserving private or public organizations, communities utilized the optimum potentialities of their existing facilities for the public inebriate. This was particularly true of medical services that were made available for detoxification.

In FY 1974, NIAAA funded a total of 20 Public Inebriate Programs throughout the country in the amount of $8,642,193.

Criminal Justice Alcoholism Program

This program supported alcoholism treatment and rehabilitation services for pre-trial releasees, probationers, inmates and parolees of the criminal justice system who were identified as alcohol abusers or alcoholic persons. This program is concerned with the entire range of persons within the Criminal Justice System who are charged with or convicted of crimes, including the four index crimes of violence (homicide, aggravated assault, forcible rape, and robbery), with the exception of the Public Inebriate and Drinking Drivers who are covered under separate programs.

Eligible applicants have been any public or private non-profit agencies or organizations. The National Institute on Alcohol Abuse and Alcoholism felt it especially appropriate that applicants were health and mental health agencies and organizations, working in cooperation with criminal justice and corrections officials.

DIVISION OF PREVENTION

The Division of Prevention experienced an expansion of its activities in Fiscal Year 1974. Of major significance was the addition to the Division of the National Clearinghouse for Alcohol Information, a wide-ranging communications effort to prevent the problems of alcohol abuse and alcoholism before they start and to assist those in present need of help.

The Division of Prevention also stepped up its activities in its other areas of responsibility: Youth Education, Community Prevention, Training and in supervising the efforts of the National Center for Alcohol Education.

The Division derived its authority for its prevention duties from Public Law 91-616, the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970.

The objective of this Division is the prevention and control of alcohol abuse and alcoholism in the United States and its territories and possessions.1

The Division's Branches developed, implemented and evaluated alcohol abuse and alcoholism prevention programs to meet the needs of the diverse American population. In this wide spectrum, most persons display responsible attitudes toward the use of alcohol. However, 9 million Americans suffer from the disease of alcoholism. Millions more are drinking today who may someday become alcoholic persons or alcohol abusers. It is toward the latter population that the efforts of the Division were aimed. A total of $6,793,256 was expended for Prevention grants and contracts. This consisted of 40 grants amounting to $6,456,842 and four contracts in the amount of $441,414. In addition, the Division of Prevention awarded $4,545,500 for the administration of the National Clearinghouse for Alcohol Information, and $1,677,533 for the administration of the National Center for Alcohol Education.

The Division provided the monitorship of these two larger contracts and has utilized this element of the Institute's program to facilitate the sharing of prevention and other relevant data with a variety of groups and organizations at National, State and community levels.

Youth Education Branch

The prevention effort of the Youth Education Branch essentially falls into two main thrusts. The first aspect consists of developing awareness among the Nation's youth that alcohol is a drug, that it can provide certain satisfactions if used responsibly, and that it can result in severe illness or in physical harm due to accidents if used irresponsibly. Once this issue becomes a relevant topic to youth and attains enough significance to motivate involvement on their part, the second aspect of the Branch's prevention effort becomes crucial. This second aspect requires our providing substantive backup to youth-serving organizations and to individual youths who become motivated to learn more about responsible alcohol use or non-use and who wish to participate in or initiate alcohol abuse prevention efforts.

During the first year of existence (FY 1973), the Youth Education Branch focused primarily on the second aspect of its prevention program. In FY 1974, the program began to direct much of its resources toward stimulating the interest and involvement of large numbers of youth and youth organizations across the country and toward utilizing the experience of the first year in providing these groups with technical assistance as they begin to mount their own programs. By supporting and coordinating the efforts of national organizations such as the Education Commission of the States, the National Congress of Parents and Teachers, the National YMCA and others, the Youth program has attempted to work collaboratively with these organizations in preparing youth to make responsible decisions regarding the use and non-use of alcohol, and to provide youngsters with opportunities to exercise responsibility and authority at an early age.

During FY 1974, the Youth Education Branch attempted to identify and pursue a wide variety of conduits for reaching youngsters. These conduits have included parents, peers, teachers, health care providers, and other adults who are recognized by youngsters as role models or leaders. A limited number of demonstration project grants were funded to test the feasibility and effectiveness of different strategies in communicating with youngsters around the subject of responsible use and non-use of alcohol. These grants utilized such approaches as the peer modeling concept, teacher training, development of family communication skills, and school-community endeavors. In addition to these action projects described above, one research grant funded in FY 1973 was completed in FY 1974. This project studied the impact of mass media upon youth

alcohol information seeking behavior. In addition, a research grant was funded in FY 1974 which provided for a 17-year follow-up study on the psychological and social adjustment of the children of alcoholic and non-alcoholic parents. The total grant effort amounted to seven grants in the amount of $1,663,440; four grants were second year funding in the amount of $591,651 and three were new grants in the amount of $1,071,789.

In addition to the above efforts, one contract was awarded to the National Congress of Parents and Teachers in the amount of $97,765 and two modifications to an existing contract with the Education Commission of the States in the amount of $141,649, totaling $239,414 as contractual effort in the Youth Education Branch. The Education Commission of the States established a Task Force to examine various approaches to alcoholism prevention at a local school district level and will recommend a course of action to NIAAA in FY 1975. They will also provide in FY 1975 program planning and implementation services to States in their alcohol prevention programs, giving particular emphasis to teacher and school administrator training and local school curriculum and delivery systems.

In addition, a conference pertaining to runaway youth, their parents, and alcohol abuse, was a joint effort between both the youth prevention and treatment program.

At the end of FY 1973, the Youth Education Branch contracted for the development of preliminary designs for a Four Model Learning System in Alcohol Education. These models were targeted toward medical students, nursing students, Civil Service employees and their families, and youth in the elementary school system. The preliminary designs were submitted to NIAAA in FY 1974 and are available to any State which wishes to utilize this information in the development of its own curriculum and/or other materials.

During FY 1974, the Youth Education Branch also developed a pamphlet entitled "Teaching About Drinking" which is available through the National Clearinghouse for Alcohol Information. Other materials initiated during this period included the development of six trigger films by the University of Michigan for use with high school students. These films will be completed and made available through the Clearinghouse during FY 1975.

Community Prevention Branch

The Community Prevention Branch became operational in September 1973. It was determined that the goal of the Community Prevention Branch is the development of effective programs in preventing the misuse of alcoholic beverages, and the health education of the community in regard to the use, misuse and non-use of alcohol.

The experiences during FY 1974 have indicated a need to make primary prevention activities a major consideration of the Community Prevention effort. Alcoholism treatment programs have often included secondary prevention activities, but little has been done in the primary prevention area outside of school programs and some mass media programs. This concentration is not intended to minimize early casefinding and early treatment programs, but the need for new programming in primary prevention became apparent.

Programs were developed that reflected a positive outlook towards the prevention of alcohol abuse.

Community prevention programs included working with voluntary agencies as Federal programs by themselves could not attain these prevention goals and objectives; therefore, it became necessary to encourage that State and Federal programming engage the voluntary sector in jointly participating in this cause.

During FY 1974, the Community Prevention Branch awarded a total of 33 grants in the amount of $4,793,402 and one new contract in the amount of $97,000. Twenty-seven of the 33 grants were awarded late in FY 1974 for State Prevention Coordinator Grants in the amount of $1,483,626. This grant program was an expression in part of the intent of NIAAA to support on a national scale a major effort directed to preventing problems resulting from the use of beverage alcohol. It has made available to each of the designated State Alcoholism Authorities a trained State Prevention Coordinator. It is expected that the Coordinators' activities will emphasize the primary prevention of alcohol problems. Such activities included: public education and public discussion, a citizen study of the community's drinking patterns, the development of strategies to prevent drinking problems, and other actions designed to reduce the incidence of alcohol abuse and alcoholism.

In addition to the 27 State Prevention Coordinator Grants, six project grants of the 33 were funded in the amount of $3,309,776; four were new grants, and two were ongoing grants. These six grants provided for public education programming in the responsible use of beverage alcohol, training in prevention activities for community workers and assistance to social agencies in their effort to assume a more active role in the prevention of alcohol problems.

Two contracts were awarded in FY 1974 in the amount of $202,000. One carried on a model community-wide education endeavor against the problems of alcohol abuse and cigarette smoking; this effort was performed in the amount of $105,000 under a reimbursable agreement with the Center of Disease Control, National Clearinghouse for Smoking and Health. The other contract in the amount of $97,000 was awarded to the General Federation of Women's Clubs. This effort developed awareness and understanding of alcohol abuse prevention among a federation of women's group organizations.

National Center for Alcohol Education

The National Institute on Alcohol Abuse and Alcoholism established the National Center for Alcohol Education at the end of May 1973 as part of its legislative mandate to manpower development related to the prevention and treatment of alcohol problems in American society. The primary goal of the Center is to improve the effectiveness of alcohol related services through the education of policy makers, and through the development of curriculum materials and model training programs which can be widely used by practitioners in the field. The Center is essentially a developmental institution rather than a direct service provider in respect to alcohol education and training.

The hallmark of the design of training programs at the Center is the utilization of a planning process which systematically produces pro forma objective based curriculum. This process requires experimental work in carrying out task analysis of service functions and the development of instruments for measuring the needs of selected participants performing the services.

The spectrum of educational activities in Fiscal Year 1974 included seven leadership seminars for policy makers in the field of alcoholism held at the NCAE and in Connecticut and Florida; planning conferences for the directors of 48 summer schools of alcohol studies and for judicial educators. The development of model instruction programs for halfway house administrators, military program administrators, trainers in the field of alcoholism, occupational program consultants, and community mobilizers. Six curriculum packages were designed to be delivered by occasional educators.

NCAE has provided professional support to the development of Area Alcohol and Education Training Programs (AAETPs); initiated a survey of existing training and education programs; and attracted a selected group of scholars and fellows from disciplines not ordinarily represented in the study of alcohol problems to act as catalysts in their respective fields and to bring their expertise to bear on problem-solving in alcoholism.

The function of the Center was administered and performed by contract by the University Research Corporation during Fiscal Year 1974 for the amount of $1,677,533. The total contract was for $3,637,533, of which $1,960,000 was the contract expenditure in Fiscal Year 1973. The Division of Prevention undertook the general monitorship of this effort during Fiscal Year 1974.

NATIONAL CLEARINGHOUSE FOR ALCOHOL INFORMATION (NCALI)

The National Clearinghouse for Alcohol Information is an information service of the NIAAA. Its job is to search out information worldwide on alcoholism prevention, treatment and research, and share this knowledge with both the professional community and the general public.

Fiscal year 1974 was NCALI's second full year of operation. It was funded during this time by a $4,545,500 cost-plus-award-fee contract with the General Electric Company. The Clearinghouse's second year witnessed the expansion of existing programs and the addition of new information projects in support of NIAAA goals. Highlights of these efforts during FY 1974 included:

-- Engaging in an aggressive outreach program to seek out potential users of Clearinghouse services.

-- Publishing an Information and Feature Service and a quarterly bulletin offering news of developments or state-of-the-art reports in the field.

-- Assembling bibliographies on various aspects of alcohol and alcoholism and supplying abstracts of studies in specific alcohol-related areas.

-- Spreading the NIAAA theme of responsible drinking through public service announcements, posters, and other materials distributed for use by local alcoholism groups and the media.

-- Assisting NIAAA's prevention program through a new Information Dissemination Program designed to enlist the aid of existing organizations--schools, industries, service clubs--in the campaign against alcoholism.

Acquisition and Processing of Literature

The Clearinghouse's job as an information center collects literature on all aspects of alcohol and alcoholism from all possible sources around the world. NCALI's information system centers around a reference library and data repository which contain more than 40,000 items, including books, audio-visuals, journals, magazines, lay literature, microfilm and abstracts of documents. During FY 1974 some 11,000 items were added to the collection, ranging over such fields as research, education, grant information and legislation. The reference library is used by NIAAA and researchers from all over the world.

The information is gathered, processed, analyzed and entered into a computer data base. A new Quality Evaluation System initiated in FY 1974 evaluates the literature acquired by the Clearinghouse.

Reference Services and Processing of Requests

The Clearinghouse reviews and processes thousands of requests each month from researchers, physicians, alcoholism counselors, program administrators, clergy, educators, students and the general public. In FY 1974, NCALI answered 127,516 requests.

Current Awareness Services and Materials

Current Awareness Service is responsible for the Clearinghouse's outreach program. This effort is aimed at providing key groups in such fields as medicine, law enforcement, social work and industry with greater knowledge and insight into the alcoholism problem. The purpose of Current Awareness is both to search out new users of Clearinghouse services and to keep all registered users up-to-date on new developments in the alcoholism field.

An Information and Feature Service provides brief reports on treatment and prevention, new publications, meetings, new grants and other information. During FY 1974, mailings reached 834,627 registered users. A quarterly bulletin, Alcohol Health and Research World, provided in-depth information on such topics as occupational alcoholism, research and treatment innovations. A total of 23,728 bulletins were sent out in FY 1974.

Current Awareness Services provide two additional services to keep its users informed. Grouped Interest Guides are bibliographic updates of new documents in 15 different categories. During FY 1974 Guides were mailed to some 15,362 persons. Individualized Interest Cards are issued monthly and allow the subscriber to be more selective in choosing his topic of interest. In FY 1974 Individualized Interest Cards were mailed to 15,617 persons. Through its varied services and materials, Current Awareness contacted an estimated 1,662,345 users during FY 1974.

Information Dissemination Program

In March 1974 the Clearinghouse began its Information Dissemination Program. At the core of this program is a plan to communicate the message through existing organizations--industrial firms, unions, schools, colleges, clubs, professional groups. The goal is to make these organizations aware of the impact of alcoholism and alcohol-related problems in America and to get their commitment to taking action.

Among the projects underway in support of this effort are:

1. Fortune 500. A special effort was made to establish personal contact and deliver two films and literature to the leading industries in this group. More than 350 firms asked for follow-up, expressing a high degree of interest in setting up industrial alcoholism programs or obtaining additional information for improving existing programs.

2. State Communicators. The goal of this project is to enlist the aid of the people in each state who deal with the media and other outreach targets. In early June 1974 the Clearinghouse held a State Communicators Conference in Washington to share information and new materials and to develop a closer working relationship between NIAAA and the states.

3. Youth Program. During FY 1974, in conjunction with the Youth Education Branch of the Division of Prevention, development of a comprehensive approach to prevention for young people was begun. Involving schools, youth organizations, parents and peer groups, the program is designed to generate a sense of responsibility toward the use of alcohol from infancy onward.

4. Service Clubs. Using Rotary, Lions and Kiwanis, this effort is getting clubs and organizations to devote a portion of their civic energies to the subject of prevention of alcoholism.

5. Foundations. The goal of this project is to contact selected foundations initially to suggest that they direct some of their resources toward information and education on alcoholism.

6. Other projects included in the new Information Dissemination effort are: a new traveling exhibit, a supplement on alcohol in Sunday newspapers, an alcohol communications project on college campuses, and a 37-city tour of news conferences and public appearances as a follow-up to the issuance of the Second Alcohol and Health Report.

Other Clearinghouse Programs

The Clearinghouse operation encompasses several other programs and support services, including the following:

-- NCALI serves as a Clearinghouse for the Department of Transportation's National Highway Traffic Safety Administration (NHTSA). This project involves warehousing of NHTSA standard pamphlets, responding to NHTSA inquiries from the general public, responding to technical inquiries involving searches and correspondence and including technical articles in Clearinghouse publications.

-- The Clearinghouse supports NIAAA's inter-agency agreement with the U.S. Navy's Alcoholism Prevention Program through the preparation and dissemination of special information material, as well as inclusion of all pertinent Navy installations on NCALI mailing lists.

-- The Clearinghouse also maintains a program of quality assurance to assess the overall operation, performance and adequacy of services. This group is concerned with the timely and appropriate response to all inquiries, as well as with a new Quality Evaluation System to evaluate the alcoholism literature.

Distribution of Pamphlets in Supermarkets

A contract in the amount of $61,152 was let by the Institute to distribute and stock 1,415 supermarket racks in several States with NIAAA publications pertaining to alcohol prevention, use and abuse - such as "Someone Close Drinks Too Much."

Development of a Brochure for the Navy Department

A brochure was prepared for the Navy Department for distribution as a Bureau of Naval Personnel (NAPERS) publication. It is entitled "Navy Alcoholism Prevention Programs" and contains facts about alcohol and the Navy's Alcoholism Prevention Program.

Lecture Series for U.S. Navy

A lecture series was prepared for the Navy Department under contract in the amount of $5,000 to present alcoholism, its nature and scope.

TRAINING

Extramural Training

The basic objective of the Extramural Training programs is to be a part of the total system in dealing with the explicit as well as latent problems of alcoholism. Training within the Institute is derivative; the guidelines for such programs came from the programmatic treatment, prevention and research activities. Within these constraints, the Institute provided optimal services to our population by making available better services through increased knowledge, skills and techniques of currently functioning service providers. To make these services available to more of the population in need, there was the requirement to provide for the development of new personnel and to deal with the problem of developing favorable attitudes toward alcoholic people by care givers within the entire human services system.

During FY 1974, close coordination was achieved between Extramural Training and each of the Divisions of the Institute. Furthermore, efforts were made in dealing with organizations and groups outside of the Institute to be certain that the direction of our training efforts were consistent with state and community planning.

The efforts begun in FY 1973 to change basic attitudes towards alcoholic people was continued during the current FY 1974. The pervasiveness of this problem will necessitate continued efforts in the years to come. In this current fiscal year, the Institute was successful in including alcoholism training through grant support in a number of professional fields such as social work, psychology, public health, medicine and psychiatry. The continued recognition of the importance of lay workers was a guiding principle in the development of new activities to increase the competence of those individuals as well as to increase the supply.

A significant step was taken in integrating the attack on alcohol and drugs by stepped-up support by the Career Teacher Training Program. It is noteworthy that as a result of the performance of the career teachers, there have been some shifts in the focus in the problems of addiction, some greater sensitivity to the problems and the willingness on the part of additional individuals to be involved in alcoholism and drug programs.

The Institute funded 69 training grants amounting to $8,589,000, as well as 7 fellowships for $62,000. Of the 69 grants, 23 were new and 9 were competing renewals, and 37 were non-competing renewals. In addition, 7 supplemental awards were made.

Of particular significance was an award to do a feasibility study to develop an Indian counselor training program. The purpose of this study, still in progress, is to identify models which might be useful for an Indian developed and Indian operated counselor training program. There is increased need for training programs which can meet the specific needs of Indian people.

The Research Fellowship Program was able to implement research training. Priorities were in the clinical and behavioral areas for postdoctoral research fellowships.

Being aware that results can be achieved by using the resources of other agencies who help carry out the mission of Extramural Training, contracts were made with the Rehabilitation Services Administration to attempt a joint agreement of their supporting groups and to reach a population of individuals who might be difficult for this Institute to contact directly. While no formal agreement has been reached, a real working relationship has been developed for the treatment of alcoholic people.

Extramural training made an effort to develop more and more local support in order that the phase-out of Federal support can be seen in the next two or three years.

A beginning thrust has been underway to provide training in family therapy skills for the alcoholism counselor with modest support to a grant applicant experienced in the family treatment of alcoholism problems. This was achieved by delineating the level and quality of training necessary to provide treatment for families with alcoholism problems.

Area Alcohol Education and Training Programs (AAETPs)

The Area Alcohol Education and Training Programs (AAETPs) were established in response to the overriding concern of manpower needs in the alcoholism field. As a result of the rapid expansion of alcohol treatment programs and emergence of prevention and early detection programs, the existing alcohol manpower force has been unable to meet the demands placed upon it. The AAETPs, in cooperation with the National Center for Alcohol Education (NCAE), were established for the purpose of enriching and expanding local resources to fill area education and manpower needs. The focus of the program is to identify area, State and local manpower needs and to quickly respond to those priorities as established by the Programs.

The NIAAA plans to continue its support of training programs through its present extramural training grant program. However, it has become clear that certain areas of training require an immediate response to local planning and coordination in order to create ways of delivering manpower training services which have not been provided through the usual mechanisms. It is, therefore, the Institute's intention to request present training and service programs in alcoholism and alcohol abuse to join together to enrich and expand their present efforts to provide public education and training. It is the Institute's goal that all training resources presently available should be utilized for the formation of the AAETPs and should be collaboratively involved in the planning.

The NIAAA funded four AAETPs to cover the geographic areas of the East, South, Midwest and West. Each AAETP did receive $625,000 for its first year operation, and $500,000 the second year with the possibility of a third-year of funding later. This is start-up money and the AAETPs will be expected to demonstrate how State, local and private interests will eventually assume the responsibility for these programs. The Eastern, Midwestern and Southern AAETPs have been funded out of FY 1973 funds. The NIAAA expects to support a modest, effective, central staff in each AAETP to perform educational and administrative functions for each AAETP. It is not the purpose of these grants to establish a new center or new facility for training purposes, but to enhance existing programs through subgrants and/or subcontracts.

DIVISION OF RESEARCH

Extramural Research Branch

During FY 1974, the Extramural Research Branch received 161 competing applications for research for projects on a wide variety of problems associated with the use and abuse of alcohol. This was a decline of 21 from the number of applications received in FY 1973. Sixty-one applications were recommended for approval and these were added to the 96 approved applications carried over from previous fiscal years.

At the close of FY 1974, the Extramural Research Branch funded 179 research grants in the amount of $12,695,027 and one new contract and three modifications to existing contracts in the amount of $114,231, totalling $12,809,258 as expenditures. This includes 123 new or competing renewal grants, 56 noncompeting renewal grants, and includes one chairman's grant for the Initial Review Group in the amount of $95,000. These grants were for basic and applied studies on behavioral and biomedical aspects of the effects of alcohol abuse, treatment and rehabilitation, prevention and on the etiology of alcoholism.

Grants for University-Based Centers

During FY 1974, funding was continued for two grants awarded to university medical schools for the support of multidisciplinary research programs. The center-concept for research support appears to have accomplished its purpose of stimulating alcoholism research and recruiting qualified researchers into alcoholism research. Therefore, funds for research are being provided for support and it is expected that some continued funding will be made available for distinct projects. The remaining center is in its final year of committed support and will have to recompete for funding in the next fiscal year.

Biomedical Studies (Biological)

Approximately half of the grants and funds were awarded for basic and applied research into the biological aspects of alcohol effects. Research continued on the etiology of liver cirrhosis and other alcohol-related diseases, and the study of the withdrawal syndrome and its treatment. In addition to investigating the mechanisms and enzymes responsible for the metabolism of alcohol, increased interest has been generated in the effects of alcohol on the neurochemistry of alcoholism. The interrelation between alcohol ingestion and vitamin deficiency has been studied and research has been conducted on the effects of alcohol on nerve cell membranes. It is hoped that these studies may help to explain memory impairment associated with alcoholic Korsakoff syndrome and how alcohol induces intoxication.

Over the past year, the Institute has encouraged research to demonstrate whether chronic alcohol abuse by mothers results in birth defects in their offspring. The original research included only a small number of children and there is not certainty that the effect is genuine. The Institute has funded four grants to determine the prevalence, type and severity of the birth defects and whether the defects can be induced in sub-human species. Research needs to be done on other aspects of this problem including a determination of the permanence and reversibility of the defects, their susceptibility to treatment, possible implication of paternal alcoholism and the possible induced predisposition to alcoholism in later years. Research findings in this area would have important implications for early identification and treatment of children of alcoholic parents and primary prevention of alcoholism.

Some research continues on the development of pharmacologic agents with possible usefulness in blocking the effects of alcohol on the brain. In addition, two new grants were awarded for studying long-acting microencapsulated agents which would reduce alcohol intake and for identifying the active ingredient contained in the mushroom, coprinus atramentarius, which induces a sensitivity to alcohol.

Five studies are now devoted to assessing the genetic-ethnic influence on alcoholism. Previous research suggested that genetic inheritance may be involved in the high risk that children of alcoholic parents have to develop alcoholism. The new studies are focused on genetic-ethnic difference in sensitivity to alcoholism. In one study, differences in alcohol metabolism is being studied in four different ethnic groups, including Japanese, Chinese, Neo-Hawaiians and Caucasians.

Studies of Treatment (Clinical Research)

The Extramural Research Branch continued to emphasize the need for research on new treatment methods. The number of clinical research projects increased to 33% of all research grants funded in FY 1974.

Research on specific treatment methods were divided into three groups: Pharmacologic, Behavioral-Psychiatric, and Community Systems. Two projects were concerned with the evaluation of lithium in the treatment of chronic alcoholism and two projects involved the use of disulfiram in the concurrent treatment of alcoholism and drug addiction. Behavioral-Psychiatric approaches to treatment include aversive conditioning and other behavior modification approaches, the use of Alcoholics Anonymous and other self-help groups and the study of interactional patterns of marital dyads having one alcoholic spouse. New research is now being funded to evaluate the changing system in the management of public inebriates, evaluating a model for treatment programs and the assessment of a system monitoring Federal-State programs.

Other Activities

An important program activity of the Extramural Research Branch is to identify and stimulate research in underdeveloped or promising areas. As a direct consequence, increased research activity is evident in the specific areas of youth, women and the family as well as in the general area of clinical research. In addition, the Branch has the responsibility of facilitating the dissemination of new research findings in order to enhance their rapid utilization by the therapeutic community and to provide a forum for researchers to communicate with other scientists on problems of mutual interest. To accomplish these objectives, the Extramural Research Branch planned and conducted the research program of the Institute's Annual Alcoholism Conferences and other conferences on specific problem areas and research workshops.

The research program presented at the Fourth Annual Alcoholism Conference in Washington, D.C. was divided into (a) the Behavioral Research Session which included a discussion of alcohol and craving, a panel on counter-measures for the drunken driver, a paper on biofeedback as a treatment technique, a community approach to alcoholism and an assessment of factors contributing to poor morale in treatment personnel, and (b) the Biomedical Research Session which had three presentations on anti-alcohol agents, hepatic and intestinal injury, and the effect of alcohol on offspring.

Conferences

Under the auspices of an extramural research grant, funding was provided for partial support of the North American Congress on Alcoholism and Drug Abuse to be held in San Francisco December 12-18, 1974. In addition to providing financial support, Branch staff have been involved in the planning and coordination of the research program of the Congress.

Research Workshop

The workshop mechanism is designed to bring together a small number of experts to discuss a specific problem area in alcoholism. On May 6-8, 1974, the Branch sponsored a workshop on "Alcohol in the Context of the Family." Twenty experts in alcoholism and sociology, psychiatry, and public health were brought together at Airly House in Warrenton, Virginia, to discuss the several aspects of alcohol and family dynamics. The product of the workshop did include recruitment of qualified scientists into alcoholism research and the stimulation of new research in this area.

Program Evaluation

A contract has been let and work is proceeding to delineate the size, structure and importance of the research work reported in the primary alcohol research literature. The contractor is describing and mapping the primary alcohol literature and characterizing the work reported therein and the changes that have occurred between 1967 and 1973 with particular attention to the possible role of NIAAA.

Collaborative Research

In addition to the above activities, staff of the Extramural Research Branch conducted research in collaboration with non-Institute scientists. Because of the press of extramural grant activities, no new data have been collected. Further analysis of data concerning blood alcohol levels in fatal motor vehicle accidents is continuing. One paper has been published which shows that higher blood alcohol concentrations are found in drivers killed in one-car than two-car accidents, in nighttime than daytime accidents and, among drivers under age 30, in weekend then weekday accidents. The peak occurrence of single car crashes was found at a younger age than the peak blood alcohol concentration, suggesting that some age-related factor in addition to drinking is involved. Additional papers from the data already collected are planned.

Intramural Research Programs

Laboratory of Alcohol Research

In September 1973, a multidisciplinary research Task Force was appointed to conduct an in-depth assessment of ongoing research at the Institute's Laboratory of Alcohol Research. The members of this Task Force were distinguished scientists from American universities, foreign alcohol research laboratories, and individual Institutes within the National Institutes of Health, each of whom possessed expertise within his chosen discipline, i.e., medicine, psychiatry, psychology, biochemistry, pharmacology, pathology, sociology, and research administration. After extensive deliberations, the Task Force recommended changes and modifications of emphasis in NIAAA's intramural research programs.

After analysis of the Task Force's recommendations, a reorganization of the Laboratory was initiated which is expected to be completed by July 1, 1975. In FY 1974, the mission of the programs was established as follows:

The Biochemistry Program - To perform research on the metabolic and toxicologic effects of ethanol in experimental animals. The findings and results will stimulate new directions in extramural research and sustain the Laboratory as a center of excellence for research on the metabolic consequences of ethanol ingestion.

The Behavior Program - To conduct studies toward understanding endocrinologic and behavioral determinants within the organism which induce alcohol ingestion, the consequences of such ingestion, and the factors which mediate and/or regulate ethanol intake. Understanding of factors controlling alcohol intake will result from this research and will provide knowledge concerning deterrents and/or countermeasures which, with further research and study, may prove suitable for application to humans.

The Clinical Program - Will perform (1) treatment and care of alcoholic individuals with alcohol-related diseases of the liver, brain, and heart, in a hospital setting; (2) research on alcoholic patients designed to elucidate the clinical disease state induced by alcohol ingestion; and (3) serve as the national center for training paraprofessionals in the care and treatment of alcoholic persons. At present, no university has a department of alcohol studies. This center will be the sole facility in the Nation which affords training of paraprofessionals to head up other alcohol treatment centers throughout the U.S.

The Neuroscience Program - Studies will be directed toward understanding the basic mechanisms governing alcoholic complications, addiction, and withdrawal, including the molecular components involved in each of these processes. In addition, studies will be made of genetic factors affected by alcohol ingestion. Findings within these areas will provide an international first in understanding the molecular bases for behavior which, in turn, could lead to complete elimination of alcoholism.

Despite the rather drastic reorganization taking place within the Laboratory, productivity as judged by the publication of research results appeared reasonable.

Biochemistry Program

The biochemistry studies have been directed at developing new methods which will allow a clearer understanding of how ethanol interacts with living cells. The bulk of work has been concentrated on the liver and brain where the toxic effects of ethanol are most severe.

Brain Studies

Brain studies were begun by developing methods which allowed the study of effects of alcohol intoxication, addiction, and withdrawal in the brains of conscious living animals. The brain was removed and frozen within .1 sec., which allowed study for the first time of the subtle changes in brain metabolism which accompany intoxication, addiction and withdrawal. Veech et. al., Research Methods in Neurochem. (1974) vol. 2 pp. 171-182 Plenum Press, New York. Attempts to develop rapid microwave irradiation so as to study specific brain regions showed promise and will be continued. (Guidotti et. al. Neuropharmacology, 1974, in press). A third new method allowed the measuring of what went into and came out of the brain of the conscious rat (Hawkins et. al. Research Methods in Neurochem. Vol. 2, pp. 161-170, 1974). The fourth new method gave a measure of the total overall energy consumption of brain in different physiological states such as intoxication or withdrawal (Hawkins, et. al. J. Neurochem., in press, 1974). Taken together these methods provided a better understanding of the function impairment of brain which was produced by excessive alcohol ingestion on the one hand or withdrawal from ethanol after addiction.

Use of these newer techniques has raised questions about earlier findings concerning the levels of the important second messenger in brain C-AMP (Lust et. al. Science 181, 280-282, 1973). These studies showed that the response of brain free NAD+/NADH, which is the fundamental source of cellular energy, differs markedly in brain when compared to liver. This implied that brain alcohol dehydrogenase has little physiological significance whereas it is of major significance in producing the liver toxicity of ethanol (Veech, 1974, in Alcohol and Aldehyde Metabolizing System, pp. 383-394, Academic Press, N.Y.).

In an independent study, comparison was made on the effect of chronic ethanol intoxication with chronic ingestion of the nonintoxicating dimer of ethanol, k, 3, butandiol, in an attempt to determine which brain changes were of toxicological significance. (Veech et. al. Toxicology & Applied Pharmacology 29, 196-203, 1974). In the same physiological state, neither the levels of brain dopamine nor norepinephrine were changed but the turnover of brain dopamine was descreased during withdrawal (Hunt et. al., J. Neurochem., in press, 1974). The uptake of norepinephrine by synaptic vesicles was unaffected either by ethanol or acetaldehyde (Lahti et. al. Quart, J. Alc. Studies 35, 1-14, 1974). In view of the extensive speculation as to the possible role condensation products of acetaldehyde with biogenic amines might play in the withdrawal process from alcohol addiction, improved methods for the accurate measurement of acetaldehyde will be developed during the next year. To date, however, the studies gave no support to the importance of this hypothesis as an explanative feature of the alcohol withdrawal syndrome.

A common terminal event in chronic alcoholism is hepatic coma which is thought in part to be caused by failure of the liver to remove blood amonia. The effects of elevated ammonia on brain function were studied in an attempt to design more effective therapy (Hawkins et. al. Biochem J. 134, 1001-1008, 1973). Finally, these same techniques were used to evaluate

the causes of death in infants which result from use of the household germicide hexachlorophene. (Harris et. al., Pediatrics, 54, 118-119, 1974).

Liver Studies

It had earlier been shown in this laboratory that many of the toxic effects of ethanol on liver result from a distortion of the free NAD+/NADH ratio which follows the metabolism of ethanol by hepatic alcohol dehydrogense. One of the earliest pathological changes to be observed in the liver of alcoholics is the accumulation of fat. It follows that alcoholic fatty liver is most often the first serious physical ailment suffered by these people. The mucleotide which is primarily involved in the synthesis and degradation of fat is acetyl CoA. No information was available at the start of these investigations on the free or chemically active acetyl CoA/CoA ratio, nor was it possible to measure the concentration of the first committed precursor of fatty and synthesis, malonyl CoA. Therefore, the investigations were planned and focused into the causes and treatment of alcoholic fatty liver in order to determine first these two previously unknown quantities, the free acetyl CoA/CoA ratio and the concentration of malonyl CoA. The results of these investigations were presented at the Royal Danish Academy and summarized the new knowledge on the control of fatty acid synthesis (Veech et. al. in Control of Hepatic Metabolism, 1974, Lundquist and Tygstrup eds., pp. 337-359, Academic Press, New York). This increase in the basic understanding first required a number of preliminary studies to create methods of measuring: malonyl CoA Guynn et. al. Methods in Enzyonology vol. 35, in press, 1974, and the concentrations of long chain acyl CoA, an improtant inhibitor of fatty acid synthesis. (Veech et. al. Methods in Enzymology, vol. 35, in press, 1974. Having first understood the fundamental process, the investigators were able to correct the prevalent misconception that ingestion of alcohol causes increased hepatic synthesis of fat. The studies showed that acute ingestion of alcohol does not result in an increased synthesis of fat in the liver (Gugnn et. al. Biochem. J. 136, 639-647, 1973). These investigations are now being extended to include the effects of chronic alcohol ingestion in addition to the study of the factor responsible for the control of cholesterol synthesis. It is obvious that understanding of these processes have important implications not only for alcoholic fatty liver but for the understand of arteriosclerosis which is currently the number one killer in the United States.

Studies on the Metabolism of Ethanol

In addition to studying the effects of ethanol of fat synthesis, studies were continued on the metabolism of ethanol itself. A number of suggestions have been raised as to ways to increase the rate of ethanol metabolism. It is obvious that in the unlikely event that such a "sobering up" procedure could be devised, it would be useful in cutting down the rate of traffic deaths. In one study, it was shown that the use of the anticholestorolemic agent "chlofibrate" increased the rate of ethanol disappearance not by fundamentally increasing its metabolic rate but simply by increasing liver size (Hawkins et. al. Biochem J. 140, 117-120, 1974).

The fundamental process which appears to govern the rate at which ethanol can be metabolized is the rate at which the NADH produced by the oxidation of ethanol can be disposed of by oxidative phosphorylation. The control of the rate of oxidative phosphorylation and its relationship to the ATP/ADP x Pi ratio which is distorted by ethanol was investigated more fully and the principles regulating the process elucidated. (Ericnska et. al. Arch. Biochem. Biophys. 160, 412-421, 1974).

Studies on the Distortion of the Role of Pyrophosphate in Hepatic Energy Metabolism

In a related study, the distortion of the role of pyrophosphate in hepatic energy metabolism after ethanol was investigated. It has previously been widely held that pyrophosphate was rapidly hydrolysed in cells to inorganic phosphate. We were able to show that in liver cells, the level of inorganic pyrophosphate is about 4-6 moles/g. Further pyrophospate was shown to exert important controlling effect on a number of important synthetic reactions in addition to the activation of acetate which is the end product of hepatic ethanol metabolism (Guynn et. al. Biochem J. 140, 369-375, 1974). These investigations of the role of pyrophosphate in the activation of aminoacids will be pursued in particular in relation to the disturbed protein synthesis which occurs during the genesis of alcoholic cirrhosis. The role of pyrophosphate in the production of alcoholic hypoglycemia is currently being investigated.

The Behavior Program

During FY 1964, the Behavior Program was terminated on recommendation of the Task Force of Scientific Advisors until in-depth evaluation was made and new or revised mission established. This was completed in FY 1974.

The Clinical Program

During FY 1974, the Clinical Program engaged in a series of behavioral studies examining the relationship between chronic alcohol consumption and interactional behavior in families containing one or more alcoholic individuals. The program's major effort was directed toward the development and implementation of an experimental treatment program designed to explore the efficacy of multiple couples group therapy techniques applied to alcoholic families.

The therapy program contained as its central innovative feature the stimultaneous admission to inpatient setting of three couples, one or both members of which was an alcohol abuser. During this ten-day hospitalization couples were instructed to reproduce as closely as possible their usual drinking patterns and interactional behavior. The ward environment was designed to provide a stimulated apartment-like setting and alcohol was made freely available for the first seven days of the hospitalization.

The rationale for this unusal inpatient experience was to provide the therapist with an opportunity to directly observe interactional behavior during intoxication as well as sobriety. This study represented the first attempt to systematically observe sober and intoxicated interactional behavior in families with one or more alcoholic members.

Clinical observations and research findings stemming from this study have significantly increased our understanding of factors maintaining drinking in alcoholic families. Although therapy outcome results are still being analyzed, initial findings support the efficacy of family approaches in the treatment of alcoholism. Data obtained and currently being analyzed also supports the notion of the existence of significant psychopathology in the non-drinking spouse married to an alcoholic individual, and preliminary results indicate that the cessation of drinking increases symptamotology and anxiety in these non-drinking spouses.

2. Explorations of a systems approach to alcoholism: Clinical Observations of a simulated drinking gang, Archives General Psychiatry (In Press).

3. Interactional behavior in an alcoholic community, Medical Annuals D.C. 43:183-187, 1974. (S. Wolin and P. Steinglass).

4. Alcoholic families, presented at the Payne Whitney Cornell University Medical Center Annual Lecture Series, November, 1973, (P. Steinglass).

5. Multiple couples groups in the treatment of alcoholism, presented at Group Methods to Treat Alcoholism, January, 1974. (P. Steinglass).

6. Marital interaction during experimental intoxication and the relationship to family history, presented at the International Conference on Alcoholism, Manchester, Egland, June, 1974. (S. Wolin, P. Steinglass, D. Davis and D. Berenson).

During FY 1974, personnel costs for the Laboratory of Alcohol Research were $315,653. Other direct operations for the Laboratory of Alcohol Research were $59,522. Maintenance support on the facilities for the clinical research ward and animal laboratories occupied by NIAAA at St. Elizabeths Hospital amounted to $70,211. Total expenditures for intramural research during FY 1974 totalled $445,386.

NATIONAL ADVISORY COUNCIL ON ALCOHOL ABUSE AND ALCOHOLISM

Mandate

During FY 1974, the National Advisory Council on Alcohol Abuse and Alcoholism continued to provide consultation, advice, recommendations, and other assistance to the Secretary of Health, Education, and Welfare, regarding the policies and programs of the Department in the area of alcohol abuse and alcoholism. The Council made recommendations to the Secretary regarding program priorities and emphasis, as well as regarding effective policies and procedures for the coordination of activities in alcohol-related programs of various agencies within the Department.

The Council also reviewed and made recommendations on applications for grants relating to prevention, training, research, and provision of treatment and services in the field of alcohol abuse and alcoholism.

Membership

The Council was composed of 12 appointed members and two Ex Officio members.

Meetings

The Council met four times in FY 1974.

ACCOMPLISHMENTS

1. The Council's major contributions have been the provision of consistently high level scientific review and evaluation of research, training, prevention, community assistance, occupational and special project grant requests submitted for Federal support. In FY 1974, the Council reviewed a total of 992 competing applications requesting funds in the amount of $157,527,100. Of these 992 applications, 483 applications requesting a total of $56,186,258 were recommended for approval in the amount of $49,229,585 -- many of which were for over one year of program effort -- and 348 applications amounting to $54,591,436 were recommended for disapproval. One hundred sixty-one applications requesting a total of $46,767,406 were deferred for further development.

2. During FY 1974, Council made significant contributions toward the review of policy and issues related to the functions of the National Institute on Alcohol Abuse and Alcoholism (NIAAA), including:

-- Health insurance coverage for alcoholism, in which the Council's main thrust was to encourage and stimulate greater participation among private third-party carriers, for the rendering of services to and treatment of alcoholic persons.

-- Endorsement of a three-part policy regarding grant funding principles which calls for (1) the elimination of certain approved grant programs which do not meet the needs of current alcoholism programs, (2) the funding of as many proposals as feasible from FY 1974 appropriated funds and from funds released from FY 1973 impoundment, and (3) the continuation by the NIAAA of the arrangement whereby previously approved grants would not be automatically funded without an evaluation of the current status of the application, and its priority.

-- Recommendation that alcoholism materials be developed for Spanish-speaking, black, and other racial minorities, and that careful planning be given to the translation of these materials designed to reach special impact groups.

-- Statement of research priorities rearticulating the research goals of the NIAAA.

-- Participation in international activities on alcohol abuse and alcoholism.

-- Submission of a resolution, with recommendations, to the Secretary, on the Regionalization of the NIAAA programs.

3. The Council has offered, and continues to offer, innovative suggestions for the establishment and development of program direction within the NIAAA, particularly in the areas of research and prevention. Other major contributions made by Council were inputs toward the formulation of accreditation standards for health care facilities, and toward the selection of definitions for common word terminologies used both in the health care industry and in the field of alcoholism.

OFFICE OF PROGRAM DEVELOPMENT AND ANALYSIS

Development and Planning

An Operational Planning System (OPS) has been developed within the National Institute on Alcohol Abuse and Alcoholism as a procedure for management by objectives and resource allocations. Toward the end of each fiscal year, the Institute develops specific objectives which it incorporates into its operational planning system for the forthcoming fiscal year. This operational planning utilizes immediate steps that must be taken by the Institute to accomplish its long-range goals. Progress toward accomplishing these objectives is tracked on a monthly basis by the Institute Director.

Following is a summary of the major objective developed in FY 1974, including the accomplishments:

Objective

To increase health insurance coverage of alcoholism treatment.

Accomplishments

Despite the estimated nine million Americans directly harmed physically, psychologically and socially by alcoholism and problem drinking, alcohol abuse and alcoholism have been slow to receive full recognition as a major public health problem. Yet alcohol is recognized as the most seriously abused drug in this country according to the National Marijuana and Drug Abuse Commission. The high incidence and prevalence of alcoholism has created a definite demand for expansion of insurance benefits for the health care needs of the alcoholic persons equal to that accorded other illnesses.

Coverage for services provided to alcoholic persons has not developed as quickly nor fared as well as insurance coverage for solely physical illnesses. Third-party payments usually exclude or highly limit coverage for the treatment of alcoholism, particularly in relation to residential services. Further, recovery of benefits under third party payments when attainable were inconsistent from carrier to carrier.

The resultant effect was that many Federal, State and local government alcoholism agencies were treating people in very late stages of their illness. Of those admitted into NIAAA comprehensive programs, the average person had a 14-year history of heavy drinking. More appropriate insurance coverage could have made services available to alcoholic persons at earlier stages in their illness. NIAAA-supported alcoholism treatment centers received an average of almost 9% of their income from all third-party reimbursement services, while only 2% of this was from private insurance.

The insurance industry became in FY 1974 more sensitive to the needs of alcoholic individuals. Nevertheless, the majority of health insurance policies which currently cover alcoholism limit related care to an accredited general hospital, thus excluding many types of more economical treatment programs. Certain health insurance companies did take a lead to bring about change within the industry. NIAAA has increased the development in the areas of treatment effectiveness, cost data, licensing of facilities, certification of personnel, etc.; therefore, it may be anticipated that health insurance companies will expand their benefits to meet the needs of alcoholic persons.

Efforts to Increase Health Insurance Coverage for Alcoholic Patients

NIAAA, in cooperation with broad representation from the alcoholism field,

has made an effort to meet some of the inadequacies in the third-party reimbursement area for alcoholism treatment. For example, in FY 1974, NIAAA defined and scheduled a two-year operational Planning Objective (H-21) to achieve increased coverage by private health insurance companies for alcoholism treatment. This objective was instrumental in clarifying many of the issues involved in an effort to achieve its goal of reducing current health insurance exclusions or limitations related to alcoholism. This activity helped to improve the program administration and financial management capabilities of our programs in order to recover the maximum third-party funding.

Standards for Alcoholism Treatment

One accomplishment was the development of standards for alcoholism treatment services which have been lacking or inadequately defined. These new standards were developed through the Joint Commission on Accreditation of Hospitals, with the help of advisory groups and a steering committee drawn from the alcoholism field. A standards manual for alcoholism treatment programs has been designed, together with a procedure for ongoing surveys leading to accreditation. These standards are expected to be implemented in FY 1975. This contract to the Joint Commission of Accreditation of Hospitals amounted to $68,740.

Model Cost-Accounting System and Management Seminars for NIAAA Grantees

Another accomplishment was the development of a model cost-accounting system for use by alcoholism programs. This cost-accounting system had to meet the needs of alcoholism programs of varied sizes and degrees of complexity and sophistication. In FY 1975 this accounting system will be implemented in conjunction with a management assistance program. Also, NIAAA recognized that in order to capture third-party payments in NIAAA's service projects, there was a need to improve management performance on the part of project directors and key staff. NIAAA has recognized the shortage of management expertise in the programs and has thus launched a major effort to increase the the management capability of existing grantees by means of developing and the implementing seminars on such topics as financial management, with emphasis on assisting programs in becoming eligible for increased third-party payments and funding from multiple sources. These seminars were conducted during FY 1974. The technical assistance provided to the grantees in specific management areas should enhance the programs' capabilities to increase their third-party fundings. The contract for these efforts was $295,644.

Studies and Surveys Related to Health Insurance Coverage for Alcoholics

Also during FY 1974, a model alcoholism insurance benefit package was developed, which reflected the current "State of the Art" and will act as a guideline to companies providing alcoholism coverage in health insurance plans. This proposed benefit package, upon completion of thorough testing, will be made available to all State alcoholism authorities, employers, trade unions, and the insurance industry.

An initial study was conducted by contract to provide some information concerning the costs of different types of alcoholism treatment programs compared to the model benefit package. A preliminary conclusion was that it was reasonable and economical to provide care for alcoholism through the vehicle of the model benefit package in certain types of settings. With few exceptions, the model benefit package thus far seems to be adequate for dealing with the needs of most alcoholic persons for treatment services.

In FY 1974, NIAAA also conducted a study to determine what action toward health insurance coverage for alcoholism has been taken by the State health insurance regulatory agencies. This study concerning health insurance coverage for alcoholism will be distributed to all States. Both studies were performed under contract in the amount of $19,842.

Standard for Certification of Non-Degree Treatment Staff

In addition, standards have been developed leading toward certification of non-degree professional treatment staff. A survey of all alcoholism programs employing counselors, with selected site visits to verify funding, was completed. It is expected that during the coming year a "certifying" body will work to gain acceptance of the standards and to implement the certification of non-degreed alcoholism counselors. The contract to accomplish this effort amounted to $121,556.

Incentive Contracts

In FY 1974, NIAAA instituted the use of incentive contracts, a unique and novel concept in the health services procurement area, with profit making companies. NIAAA has awarded one incentive contract in FY 1974, which is to demonstrate that contractual incentives can yield facilities of a nature satisfactory both to the alcoholic population and to health insurors covering this population. It is expected that this should attract enough third-party payments to enable the contractor to become self-sustaining in a relatively short time. This contract effort amounted to $298,459.

Evaluation

In FY 1974, an established policy of the Institute was to include an evaluation component in all sponsored alcoholism programs and projects. Monitoring and evaluation activities covered research, prevention, direct services and training. The policy of continually monitoring NIAAA funded programs from their beginning and evaluating key areas of Institute activities has been followed. Findings from all evaluative activities were shared with concerned local, State and Federal agencies.

The prime purpose of evaluation was to provide a measure of the effectiveness and efficiency in the use of public funds and to provide guidance for decision-making at all levels. The Institute evaluation plan covered those activities and functional areas of highest Institute program priority and evaluation resources were directed to those areas.

Data Collection and Monitoring System

A Data Collection and Monitoring System was developed by NIAAA in order to provide system users with significant client, services, and management information on a regular and timely basis. The system was designed to gather data from individual projects funded by NIAAA and, through appropriate computer programming, to provide output reports which showed the relationships between program services, management, and client outcome. Another purpose of the Monitoring System was to provide commonality of data elements and definitions in the data gathering activities pertaining to alcoholism programs of NIAAA, states, and other agencies.

In FY 1974, the policy of NIAAA was that all direct service programs will be monitored from their inception in order to gain early insights into program effectiveness and efficiency. Seventy-one projects were participating in the system during this year.

The system collected data on over 40,000 clients in its first full year of operation. This sample size, tremendous in comparison to the usual evaluation study, provided one of the richest existing data bases on problem drinkers and alcoholic persons who have come into treatment.

Changes by the comprehensive Alcoholism Treatment Centers in client's condition six months after treatment have been reported and compared to the condition of those same clients at intake into treatment.

Programs monitored by NIAAA in FY 1974 included the following:

- Alcoholism Treatment Centers	45
- Drinking Driver Program (Pilot Phase)	10 - to be increased to 17 in FY 75
- Public Inebriate Program	5
- American Indian Program (Pilot Phase)	6 - to be increased to 16 in FY 75
- Industrial Alcoholism Program	6
- Poverty Alcoholism Program (Pilot Phase)	0 - 10 to be monitored in FY 75

In FY 1974 there were approximately 500 projects in the universe of those programs cited here.

Public Education Campaign Evaluation

The education of the general public in the responsible use of alcohol was a high priority of the Institute and a mass media campaign was in progress to pursue that goal. An evaluation of the effectiveness of that campaign has provided important insights regarding changes in public awareness, knowledge and attitudes.

The overall conscientiousness of the public regarding alcohol use has continued to increase over the past two years during which surveys have been conducted. Awareness of the Institute sponsored media campaign has increased to the point that 35% of those last surveyed recalled either one or more of the messages or themes. That awareness has continued to rise since the first survey was conducted in 1972.

This evaluation activity provided revealing information regarding drinking patterns of the general population and trends in drinking patterns by various population groups.

Client Followup Study

A study has begun in FY 1974 to determine the results of treatment on a selected sample of clients from Alcoholism Treatment Centers. The purpose of the study is to learn the effects of exposure to various treatment modes and to various periods of treatment. A secondary purpose is to learn why clients terminate treatment prior to completion.

The study results should provide factual information for use in treatment improvement for all segments of the population.

Inter-Agency Cooperative Evaluation Effort

The benefits of coordination of evaluative activities among departments and agencies of government are well recognized by the Institute and coordination efforts receive a high priority. Coordination at the Federal level in the alcoholism services evaluation area was particularly significant. Actions have been taken with the Department of Transportation, Department of Defense and with the Veterans Administration. The Institute also was involved at the state level and has been working directly with the States in gaining better information regarding alcoholism.

- With the Department of Transportation, a pilot study of 10 projects serving drinking drivers continued. Its purpose was to determine effectiveness of various treatment modes. Also, the Department of Transportation has shared in the surveys conducted in connection with the Public Education Campaign Evaluation in order to gain information relative to their own efforts.

- Several Veterans Administration Hospitals involved in treatment of persons suffering from alcoholism have instituted elements of the monitoring system developed by the Institute. Liaison was maintained with appropriate VA officials for the purpose of information sharing.

- Exchange of information regarding alcoholism in the Armed Forces and involvement in specific areas of activity were results of close liaison with the Department of Defense and with individual Services.

- State Alcoholism Authorities were apprised of all pertinent activities regarding the monitoring system, Monthly reports from the system have been provided for their information regarding in-state programs.

- Also at the State level, a grant was awarded to the Council of assisting individual states in the development and implementation of alcoholism monitoring systems. The assistance provided for a commonality of data elements and definitions and relieved the individual projects of redundant data gathering efforts.

Economic Cost of Alcoholism

Study results into the costs of alcoholism revealed a significant increase over that previously determined. The findings showed that an estimated $25.37 billion a year were invested by society due to the misuse of alcohol.

Both direct and indirect costs were investigated. The areas of study included health, traffic accidents, welfare payments, crime and loss of productivity.

The study advanced the understanding and scope of the economic consequences to the nation of the irresponsible use of alcohol and provides factual data for more informed decision making in this area.

SECOND SPECIAL REPORT ON ALCOHOL AND HEALTH

The First Alcohol and Health Report in February 1972 gave a comprehensive view of the current state of knowledge about alcohol, and emphasized that alcohol was the number one drug problem of the country. In confronting the American people with the huge size and scope of alcohol-related problems, it promised to replace myths with all of the positive and negative facts about alcohol and alcoholism as they became available.

The Second Alcohol and Health Report, prepared by NIAAA and submitted to the Congress by the Secretary of Health, Education, and Welfare, in June 1974, redeemed a part of that continuing obligation. It presented new knowledge acquired from leads derived from the first Report. It included new facts which filled in some old gaps. And it contained a number of positive and negative aspects that bear careful consideration.

On the negative side, it was learned that -- (1) The excessive use of alcohol and certain cancers are importantly related. A heavier drinker (above 1 1/2 ounces of absolute alcohol) who does not smoke has approximately the same increased risk of developing cancer of the mouth and throat as a heavy smoker

(more than two packs a day) who does not drink. When heavy drinking and heavy smoking are combined, the risk jumps enormously -- to 15 times greater than among people who neither drink or smoke. (2) The economic costs of alcohol-related problems to our Nation's economy has been underestimated in the past. The new estimate of 25 billion dollars annually is 67 percent higher than the 15 billion dollar figure used in the first Report. (3) Young people are turning to alcohol and are using it more than ever -- but this near-universal use does not trouble us nearly as much as the high rate of misuse and abuse. Nearly one out of every seven male high school seniors report getting drunk at least once every week. Thirty-six percent of all high school students report getting drunk at least four times a year. (4) Alcohol abuse continues to be a major factor in highway slaughter, especially among young people. (5) Alcohol control laws and regulations are grossly ineffective in preventing or controlling the problem related to alcohol abuse and alcoholism. They are antiquated and based largely upon the social policies of the mid-1930's. Indeed, they may actually contribute to some of the alcohol problems we face.

On the positive side, this Report indicated -- (1) There is no evidence that the moderate use of alcohol is harmful to health. (2) Moderate drinkers, as a statistical group, live longer than abstainers or ex-drinkers. (3) Moderate alcohol use may be physically, psychologically, and socially beneficial to active and institutionalized older people. (4) A lower rate of heart attacks is reported among moderate drinkers than among heavy drinkers, ex-drinkers, or abstainers. (5) Enlightened, individualized approaches to the treatment of alcoholic people enjoy high rates of success, especially those provided as a part of employee alcoholism programs established by private industry and other employers.

Taken as a totality, the Report points to one basic conclusion: The wide range of devastating problems associated with the use of alcohol all related to excessiveness -- not moderation. The implication that action in two areas is required of our society: (1) We must continue developing a greater social and human responsibility in caring for the casualties of alcoholism. The quality treatment our alcoholic people need and deserve is still not readily available. (2) Of equal importance, we must now begin in earnest the task of establishing socially responsible guidelines designed to help our people avoid dangerous drinking practices. Both of these require far more than Government action. The active participation of our Nation's private sector -- especially our liquor, entertainment, education, health, advertising, and health insurance industries -- is imperative.

INTERNATIONAL ACTIVITIES

Through international cooperation, the nations of the world are provided an invaluable opportunity of using a variety of resources toward discussing common concerns in the area of alcoholism treatment and research. Toward this end, the NIAAA has funded a variety of studies to stimulate and support multinational cooperation in undertaking basic and applied research concerning the causes and the most effective methods of combatting alcohol abuse and alcoholism. In addition to a number of ongoing studies, several new projects were begun in FY 1974.

Accelerated Review of the Role of Alcoholic Beverages on the Etiology of Certain Cancers in Man (France)

The purpose of this study has been to investigate the possible association between alcohol consumption and cancer at various sites, specifically cancer of the esophagus and of the liver. The study consisted of three parts: (1) correlation studies relating overall alcoholism consumption to the incidence of cancer at different sites; (2) case control studies on the role of alcoholic beverages in esophageal cancer; and (3) specific epidemiological studies based on collaboration

with cancer registries to determine the incidence of esophageal and liver cancers in the general population and in alcoholic persons. Some preliminary results of the study were reported in the Second Special Report on Alcohol and Health and conclusions are expected to be presented in final form by September 1974.

Heredity and Environment in the Development of Alcoholism (Denmark)

It is known that alcoholism runs in families, but the relative importance of environment versus genetic factors is not known. A collaborative adoption study undertaken in Denmark by the Washington University, St. Louis, Missouri, seeks to determine (1) whether sons of alcoholic persons raised apart from their alcoholic parents have an increased incidence of alcoholism when compared with a control group of adoptees without known alcoholic biological parents; (2) whether sons raised apart from their alcoholic parents have a greater or lesser risk of developing alcoholism than sons who are raised by the alcoholic parent; and (3) whether daughters raised apart from their alcoholic parents have a greater risk of becoming alcoholic persons or developing other forms of psychopathology than do female adoptees without known alcoholism in their biological parents.

In regard to the first objective, it has been found that the sons of alcoholic persons were nearly four times more likely to develop alcoholism than were the control adoptees. The second part of the study was recently completed, and it was found that sons of alcoholic persons, particularly where parental alcoholism was of a severe nature, were about equally likely to develop alcoholism whether or not they had exposure to the alcoholic parent. The investigators suggested that non-environmental factors may be the most important determinants of alcoholism if the diagnosis of alcoholism is restricted to the most severe forms. Concerning the third objective, adopted daughters of aloholic persons are now being located and interviewed in a manner similar to that performed for the adopted sons.

Alcohol and Aldehyde Metabolizing Dehydrogenases (Switzerland)

The most recent grant in this area started in January of 1974, after an hiatus of one year from the end of the previous period of support. Earlier research by Dr. Jean P. von Wartburg, University of Bern, indicates that some enzymes responsible for the metabolism of alcohol do not have the typical form and that the enzyme may be under genetic control. Current research is attempting to explore further this issue and to develop techniques having some potential as a diagnostic test.

Prevention of Adverse Metabolic Effects of Alcohol (Sweden)

This project is currently in its second year of support. The project under the direction of Dr. A. Hugo Theorell, a Nobel Prize recipient, is aimed at understanding how a major enzyme responsible for the metabolism of alcohol works at the molecular level. During the past year, eight manuscripts have been prepared for publication. These articles report the development of laboratory methods to study relevant enzymes, and indicate that alcohol has a direct influence on oxidation of fatty acid.

Ethanol - Induced Changes in Brain Mitochondria (Canada)

The objective of this project, undertaken in Canada, is to determine the mechanism of ethanol depression and ethanol withdrawal hyperactivity of the central nervous system. Mitochondria and synaptosomes have been isolated from the brains of rats treated acutely with ethanol, phenobarbital or morphine. Chronic studies with these drugs have been carried out, including isolation of brain organelles during withdrawal.

Brain Stimulation and Alcohol Preference (Canada)

Pilot studies with rats have indicated electrial stimulation in the lateral hypothalamic area is followed by permanent preference for strong alcohol solutions rather than water. Two lines of research are now being investigated in Canada:

-- The effect of stimulation of brain sites that have functional characteristics in common with the lateral hypothalamus.

-- The effects of hypothalamic stimulation in rats that have lesions in other areas of the brain.

Effects of Ethanol on Amino Acid Metabolism (England)

This grant to Dr. Hans Krebs, a Nobel Prize recipient, was activated in December of 1973. The liver regulatory mechanism involved with alcohol metabolism is being studied. The findings have potential relevance for understanding hepatic coma and other derangements in liver function that follows chronic alcohol ingestion.

Criteria for Identifying and Classifying Disabilities Related to Alcohol Consumption (Switzerland)

The World Health Organization is conducting a study to formulate international criteria for detecting and classifying disabilities related to alcohol consumption. These will be used as a basis for establishing policies for health and disability compensation for alcoholism and its concomitants, as well as for research and clinical applications. The formulation of criteria will be achieved through the establishment of a group of 10 members from diverse countries and areas of expertise. Papers covering a wide range of topics will be prepared by various members of the group.

International Working Symposium on Alcoholism Research (Switzerland)

At the end of FY 1974 a contract was awarded to the International Council on Alcohol and Addictions to convene an international working symposium on alcoholism research in industrialized nations. The symposium will take place in Geneva during October of 1974. The symposium will address certain specific issues during its sessions, including definition of the problem, research priorities, existing treatment services, allocation of resources between research and treatment programs, and developing communication systems. A final report will be provided of the proceedings of the symposium and its results.

Epidemiology of Alcoholism in Latin American (Latin America)

Alcoholism is particularly devastating in Central and South America. A research project has been undertaken by the Pan American Health Organization (PAHO) with three general objectives:

-- Research on drinking attitudes and patterns in several Latin American cultures

-- Studies of alcohol-related traffic accidents

-- Development of centers for the study of alcoholism in Latin America and of treatment demonstration units in several cities

Concerning the last objective, a pilot Center of Studies on Alcoholism has been established in San Jose, Cost Rica. The Center is engaged in support of developing school curricula for alcohol prevention, surveys of factors influencing the process of alcoholism, a study of manufacture and use of illicit alcoholic

beverages in Central America ("guaro"), alcoholism among Latin American women, communication patterns with families of alcoholic persons, physiological factors associated with alcohol, diabetes and heart disease, and participation in a multinational survey of drinking patterns and attitudes toward alcohol use directed by PAHO at Bogota, Lima, Caracas, Santo Domingo, San Jose, and Sao Paulo.

It is hoped the results of these studies will be useful in overcoming many of the problems caused by alcohol abuse and alcoholism among our Spanish-speaking citizens.

PUBLIC AFFAIRS

During Fiscal Year 1974, the Institute's Public Affairs program continued to encompass a wide range of efforts designed to increase public awareness of the facts about alcohol use and abuse to develop responsible attitudes toward the drinking of alcoholic beverages.

Functions performed included the following areas:

-- Collection and dissemination of scientific and public information for and through the National Clearinghouse for Alcohol Information

-- Public service education campaign.

-- Media contracts

-- Preparation and clearance of publications

-- Support services

National Clearinghouse for Alcohol Information (NCALI)

The National Clearinghouse for Alcohol Information, (NCALI), the information arm of the Institute, was established in June 1972 to gather, systematize, maintain, and disseminate a comprehensive body of knowledge on alcohol abuse and alcoholism. While NCALI continued to perform many of its activities in the support of Public Affairs, it was officially transferred to the Division of Prevention in August 1973.

During its second full year of operation, NCALI established a broader range of goals and objectives which included support of both the Division of Prevention and Public Affairs activities.

Public Service Education Campaign

NIAAA's nationwide public awareness compaign entered its second full year with the development of additional radio and television public service announcements. New radio materials included "Bill & Helen, " "Don't be Polite," "Typical Alcoholic," "Treatable Disease," "Your Child," and "Getting Drunk." NIAAA's effort to generate an even wider appeal through radio and newspapers was accomplished through the Alcohol, Drug Abuse, and Mental Health Administration which disseminated five additional radio spot announcements under a special package called "Understanding Alcoholism," and a series of newspaper articles with the same heading. The radio material included "Responsible Drinking," "Plain Talk About Drinking," "Pointers on Drinking," and "Drunkenness Isn't Funny." The newspaper articles were entitled "A Treatable Illness," "Responsible Drinking," "Alcoholism and Women," and "Parents Set Examples."

Television had a significant impact on the Nation as six new public service announcements were developed and released during Fiscal Year 1974. These included "The Plague," "Typical Alcoholic," "Getting Drunk," "Drunk Tank," "Your Child," and "It's Only Beer." "The Plague" was also released in Spanish. "Typical Alcoholic" was chosen by the CLIO committee in New York City, as the best scripted public service and/or commerical announcement for television in 1974.

"America on the Rocks," a special NIAAA film on alcoholism, first released in January 1973, received the Golden Eagle Award from the Council on International Nontheatrical Events. A condensed 15-minute version also was made available to the general public. A minimum of two prints were disseminated to all 50 State Alcoholism Authorities and 500 prints were used in the NCALI's "Fortune 500" project. An introduction by the Director of NIAAA, Dr. Morris E. Chafetz, was written and filmed as a new opener for the film. A special video-taped public awareness film was produced for the Institute and included in a "Fortune 500" package disseminated to major business firms across the Nation.

Billboard posters, cocktail napkins, bumper stickers, buttons and a new series of wall posters were developed and produced for nationwide dissemination.

Because of the execellent quality of materials made available to both radio and television during this Fiscal Year, NIAAA received a large share of the highly competitive public service time made available by the electronic media to non-profit organizations.

Media Contracts

A major responsibility of Public Affairs was to coordinate speaking engagements, newspaper and magazine interviews, and appearances on radio and television for the Institute Director and senior staff members. Fiscal Year 1974 saw an intensified program of media contact as part of the Institute's overall effort to raise the public awareness level of alcoholism problems.

Through the coordinated efforts by Public Affairs, the Institute's role in the Nation's alcohol problem was given high visibility in such major publications as Time, U.S. News and World Reports, New York Times, Los Angeles Times, Chicago Sun-Times and many other major magazines and newspapers. The Institute Director, Dr. Chafetz, was featured on many celebrity television programs such as the Phil Donahue and Lou Gordon shows, in addition to CBS, NBC, and NBC news programs. Public Affairs' coordinated efforts to have the Director askkeynote speaker at the U.S. Jaycees Annual Convention in Tulsa, Oklahoma; 16th Annual Institute of Alcohol Studies in Austin, Texas; ADPA Conference in Minneapolis, Minnesota; Licensed Beverage Industry Annual Meeting in Scottsdale, Arizona; Seagrams Family Association Annual Meeting, San Diego, California; National Council on Alcoholism Conference, Denver, Colorado; National Association of Parents and Teachers Annual Conference, San Antonio, Texas; Education Commission of the States Annual Meeting, Miami, Flordia; and 21st National Institute on Crime and Delinquency, Boston, Massachusetts.

The Director was the recipient of the Mt. Airy Gold Medal Award in Denver, Colorado, where he delivered the keynote address. Wide local radio and television coverage was given to each of these personal appearances by the Director.

Publications

One of the predominate functions of Public Affairs has been its involvement in the preparation of publications to better respond to the ever-increasing interest of alcoholism by professionals and the general public. While much of this responsibility was shifted to the Division of Prevention during Fiscal Year 1974, Public Affairs did provide coordination of many publications of the Institute, From Program to Person: Towards A National Policy on Alcoholism Services; Drinking Myths;

Facts About Alcohol & Alcoholism; Someone Close Drinks Too Much; Alcohol: A Family Affair; and Audio-Visual Materials on Alcohol and Alcoholism.

Support Services

An essential responsibility of Public Affairs was to provide professional communications and information services for the staff of NIAAA. A highlist of this support activity in Fiscal Year 1974 was coordination of the Fourth Annual Alcoholism Conference. Public Affairs provided a press room, coordinated exhibits and information materials, and arranged for the continuous showing of alcohol-related films throughout the 2-1/2 day conference. More than 4,500 professional and program people from the field of alcoholism attended.

Background files were established within Public Affairs covering 42 alcohol-related subjects and special topics.

A number of film projects were coordinated with the National Audio-Visual Center including a system whereby 100 prints of "America on the Rocks" could be loaned or rented to the general public on a year around basis. Special services were provided to Gulf States Theater, Inc., to show NIAAA public service announcements at theaters throughout the South.

Public Affairs worked in close cooperation with the Licensed Beverage Industry to present a series of responsible drinking public service advertisements in Time Newsweek, U.S. News and World Report and Editor and Publisher.

Public Affairs has awarded a grant of $1,500 to the National Council on Alcoholism-Alaska Region (NCA-AR) to support a public education campaign. This campaign offers a unique opportunity of preparing special media materials to address an audience that, to date, has received only those materials designed for the Caucasian and minority groups in the lower 49 States. A full-scale, multi-media campaign is planned to distribute and disseminate throughout the state the very latest information on alcohol abuse and alcoholism obtainable, much of it to be developed and designed specifically to relate to Alaskans in their many environments from native village to oil pipeline work camps, from rural towns to metropolitan cities. To insure that the materials relate to the many native groups and native tongues, a working agreement has been reached between the NCA-AR and the Alaskan Native Commission on Alcohol and Drug Abuse (ANCADA), in that NCA-AR has provided ANCADA $430,000 to provide consultative services, design a delivery system for rural Alaska, and provide translation expertise.

In addition, an arrangement has been concluded with the University of Alaska to institute an ongoing evaluation of the effectiveness of materials produced and to measure changes in attitudes.

PROGRAM COORDINATION

During Fiscal Year 1974, the Program Coordination function was directed by the Associate Director for Program Coordination to develop and implement the objectives of its goals:

- To effect optimum coordination, liaison and evaluation of all NIAAA programs (including grants and contracts) as a total integrated system.
- To provide timely management information for decision making to the Director and all Divisions, Branches, key staff and Regional Offices, in order to provide for optimum interaction and interfacing.
- To serve as the focal point of all inter-agency agreements.
- To improve the efficiency and effectiveness by improved utilization of all NIAAA resources.

Planning

Plans were developed for each phase of the mission (1) for the Program Coordination of NIAAA programs, (2) the Management Information System, (3) Inter-agency program interactions, and (4) Performance Measurements of Resource Utilization.

Management Information System

Numerous programs interacting across several Divisions of the Institute were coordinated. The need for programmatic functional integration became apparent at all levels of management. A Management Information System for decision making and control was designed to serve the needs of the Director of the Institute and Top Management. When fully operational, it will provide for (1) the overall and detailed functional know-how of all existing and proposed programs (including applications, grants, contracts), (2) for the interfacing and interacting of all NIAAA programs and resources prior and after award, and (3) for feedback control and decision making of efforts and expenditures. This system will present the workload of the functional and subfunctional programs, manpower and financial resources committed, progress, actual expenditures and actual end performance results (patients served, students educated in prevention concepts, etc.)

This system will provide for the Director visibility of all Institute program activities. The following will be provided:

An Overall Management Information and Control System of the Entire Institute

The overall Management Information and Control System will provide for the Director and key staff a total programmatic and functional picture of the entire Institute for decision making and control. This includes a brief description of the functional programs in each Division, its workload of applications, grants and contracts, in-house studies, manpower and fund allocations. It will be a coordinated and condensed overview of the supporting Detailed Management Information and Feedback Control Systems.

A Detailed Management Information and Control System by Functional Programs

The Detailed Management Information System will provide information on each functional program in each Division, Office or by other staff.

The status of the workload, progress and number of staff assigned to each program will be available and the effectiveness will be evaluated by the results achieved. Monitorship and control of obtaining results for the Management Information will be performed by the Associate Director for Program Coordination through the programs.

A Feedback Control System

Feedback control information will be provided to and for the Director and key staff for decision making: (1) on the functional scope of applications received in each Division/Office to avoid overconcentration of efforts and of expenditures in any one program area and region prior to award of grants or contracts to assure a balanced effort and workload; (2) on the functional programmatic know-how of type of grants and contracts being awarded in any area to provide for improved interfacing and interaction between programs; (3) on manpower allocation by functional programs; and (4) on effectiveness of each type of program in the communities for consideration of changing priorities, for additional support of these type of programs or phase-out whatever applicable.

Annual Report

The Annual Report for Congress for Fiscal Year 1973 was prepared by Program Coordination and is in progress for Fiscal Year 1974 in accordance with the requirements of PL 91-616, Title I, Section 102, and Part C of the Community Mental Health Centers Act. This narrative report required a description of the actions taken during the fiscal year and an analysis and evaluation of the effectiveness of all actions, services and expenditures of funds for all programs and functions of the Institute.

National Environmental Policy Act (NEPA) Implementation

The National Environmental Policy Act (NEPA) of 1969, PL 91-190, Executive Order 11514, Guidelines of the Council on Environmental Quality (CEQ), and DHEW Compliance Procedures (Chapters 30-10 to 16 of October 1973), required the coordination and implementation of this Act. This Act requires the assessment of the environmental impact of all Federal and Federally supported programs and projects before the decision to take the action and commitment of resources is made and a reassessment of ongoing programs.

Generic Analysis

During FY 1974, the Associate Director for Program Coordination, who is also the NIAAA NEPA Coordinator, addressed itself first to the performance of the Generic Analysis. This required an analysis of each of NIAAA's programs and projects to identify those programs and classes of actions that can be screened out (exempted) as they do not have a significant impact on the environment and are not subject to the NEPA requirements of assessing each application, grant, contract and ongoing program. If accepted, it will lead to the exemption of making assessments of entire groups of programs and a Statement of Inapplicability of the respective groups of programs. This Generic Analysis required the application of the total systems approach to evaluate the impact or non-impact on the environment and relevancy and review of a possible 160 criteria.

A narrative of groups of typical grants, and of contracts and specific activities conducted under these grants had to be prepared citing typical recipient agencies. The Institute is still waiting for the exemption. Numerous meetings at ADAMHA, PHS and DHEW levels have been taking place and inquiries answered of environmental evaluation panels.

Guidelines

In the meantime, guidelines have been prepared for the applicants to provide the necessary information in order for the government to make the Environmental Analysis and Assessment of new applications, continuations and ongoing grants and for contracts. An assessment may lead to: (1) A Determination of Inapplicability (DI); (2) a Marginal Impact (Minimal Impact) Statement (MIS); and (3) a Full Environmental Impact Statement (EIS) requiring a summary of alternatives and anticipated environmental impact of each alternative.

While all of these actions are mandatory and have been prepared in FY 1974, every effort is being made to get an exemption as thorough systems analysis to date has not shown an environmental impact as a result of the research, prevention, demonstration or treatment provided under the mission of NIAAA.

Evaluation of NIAAA Programs, Grants and Contracts in Rural Areas

During Fiscal Year 1974, an evaluation of NIAAA's programs regarding immediate and long-range effects in rural areas and the relationship to urban areas was prepared for the Senate Sub-committee on Rural Development to the Assistant Secretary for Human Development, DHEW, Office of Rural Affairs.

Poverty Rate Group Committee

During Fiscal Year 1974, the Associate Director served on the Poverty Rate Work Group Committee to review existing awarding and funding procedures and the Delegation of Authority responsibility and procedures of Federally funded continuation staffing grants in urban and rural poverty areas for the compensation of professional and technical personnel treating alcoholic persons. This committee action on part of NIAAA did lead to recommendations to amend the basic regulation Sec. 54.103, Determination of Urban or Rural Poverty areas to: (1) accept the NIAAA "Pseudo area concept" where NIAAA could fund grantees in a service area that would not qualify under the primary or secondary method when the service area was not consistent with the catchment area; (2) to provide for the grantee that changes from poverty to non-poverty a one-year wait for a changeover and then change to poverty while the non-poverty to poverty would be changed at the subsequent funding period; and (3) a revised Delegation of Authority was prepared by Program Coordination for NIAAA. The legislative basis, the regulatory requirements, the discussion and background for requiring change to a concept applicable to the 45 continuation staffing grants supported by NIAAA was also prepared. The ADAMHA legal council will write the regulations.

COLLABORATION AND INTERACTION WITH OTHER AGENCIES

Evaluation was performed to determine the adequacy and technical soundness of any joint or interfacing programs which relate to alcoholism and alcohol abuse. Communication and exchange of information was provided to maintain the coordination and effectiveness of such programs and activivities. Coordination was maintained to integrate inter-agency efforts dealing with alcohol abuse and alcoholism including Federal health, rehabilitation, highway safety, law enforcement and the health and welfare of the Nation. These agreements provided for the collaborative utilization of each agency's resources as appropriate.

Inter-agency activities in Fiscal Year 1974 included:

Department of Transportation (DOT) Public Education Campaign

A national advertising program was coordinated and implemented between the Department of Transportation (DOT), the National Highway Traffic Safety Administration, and NIAAA to increase public awareness of the facts about alcohol use

and abuse and to develop responsible attitudes toward the drinking of alcoholic beverages and reduce drunk driving. DOT reimbursed NIAAA in FY 1974 $742,209 of a total of $1,082,050 expended by NIAAA for the performance of the Public Service Education Campaign including extensive media contacts to provide maximum exposure on TV and radio to raise the public awareness level.

Department of Transportation Alcohol Safety Action Programs

A coordinated joint effort between NIAAA and the National Highway Traffic Safety Administration (NHTSA) of the Department of Transportation was continued through FY 1974. It served to reduce accidents caused by drinking drivers. NIAAA provided technical support, consultation and evaluation of research findings. NHTSA reimbursed NIAAA in the amount of $100,000.

Department of Labor Rehabilitation Research

In FY 1974, an evaluation was coordinated of the joint effort agreed upon in FY 1973 of the Manpower Administration of the Department of Labor and NIAAA for the rehabilitation of employed problem drinkers in the Baltimore area in an effort to retain problem drinkers on the job. In FY 1973, the Labor Department awarded a grant to Johns Hopkins University amounting to approximately $252,000. Eighty percent of this amount, $201,363, was reimbursed to the Department of Labor by NIAAA in FY 1973. It was established that for FY 1974 the funding would be on a 50/50 basis. In FY 1974 an extensive evaluation was made by NIAAA and the Department of Labor was informed that this specific project had not demonstrated sufficient progress to warrant additional support on the part of NIAAA. NIAAA transferred $21,537 in FY 1974 to the Department of Labor as its share of this inter-agency agreement.

Department of Justice-Exchange of Information for Criminal Justice Population

During FY 1974, efforts were coordinated between NIAAA and the Law Enforcement Assistance Administration (LEAAA) of the Department of Justice and the Bureau of Prisons (BOP), to provide an exchange of information on each agency's funded projects for the treatment on alcohol abuse for the criminal justice population. Liaison and coordination has been provided on a monthly basis. A joint-sponsored seminar took place between NIAAA-LEAAA-BOP in FY 1974 on detection, treatment, and rehabilitation within the criminal justice system, and dissemination of the findings and proceedings was made to the various law enforcement agencies.

National Clearinghouse for Smoking and Health-Center for Disease Control (CDC)

An inter-agency agreement that was negotiated and implemented in FY 1973 was renewed, continued and coordinated for FY 1974. The well-established program on prevention and control of cigarette smoking included during FY 1974 the component on alcohol abuse and alcoholism. It was a community-wide education endeavor against the problem of alcohol abuse and cigarette smoking. The National Clearinghouse for Smoking and Health provided program and technical services, as well as monitoring and reporting on the overall project. This effort on alcohol education reached health professionals, students, voluntary groups, adults in various organizations, the military and leadership in the mass media. The two programs reinforced each other in seeking to help people make better personal cooices as to take-up, cessation, modification or control of smoking or alcoholic beverage use.

NIAAA provided CDC in FY 1974 $105,000 as reimbursement for their services. CDC supported the effort with an additional $155,000. The joint effort amounted to $260,000.

National Institute on Drug Abuse (NIDA) and National Institute on Alcohol Abuse and Alcoholism (NIAAA) for the National Citizens Conference on State Legislation

In FY 1974, a multi-year inter-agency agreement has been coordinated between the National Institute on Drug Abuse (NIDA) and NIAAA for the National Citizens Conference on State Legislation. This program is designed to demonstrate the value of support by professionally qualified staff of major standing, on committees, and evaluate the impact of such staff on the quality of State legislative action relating to alcoholism and drug abuse. Teams of well trained and experienced staff has been placed in selected demonstration states to assist appropriate committees over the period of a two-year legislative cycle. The knowledge gained will be disseminated to key legislators of non-demonstration states through seminars and conferences. The total program effort that will extend through FY 1978 will amount to about $2,313,353 of which NIDA will reimburse NIAAA $675,000. During FY 1974, NIDA has reimbursed NIAAA for its effort during FY 74-76 $390,000.

Department of Defense-Alcohol Programs Activity

Programs and agreements were coordinated with the Department of the Army and the Department of the Navy under which NIAAA provided consultation services and support in the creation, implementation and evaluation of their programs.

In FY 1974, the Department of the Army (DA) reimbursed NIAAA with $13,579. for consultation services to the Army Alcoholism Program pertaining to psychological, sociological and other nonmedical aspects for the prevention, treatment, and rehabilitation of military and civilian personnel.

(Technical support provided by NIAAA is described in the Special Treatment and Rehabilitation Programs.)

The Department of the Navy reimbursed NIAAA in FY 1974 in the amount of $128,274 for consultations, evaluations of treatment centers, development of presentation materials with the objective of prevention of alcoholism to counteract present social attitudes and pressures in the Navy that are conducive to drinking and promote the abuse of alcohol. (Technical support provided to the Navy Department by NIAAA is described in the Prevention Programs and the NIAAA-Clearinghouse.)

Social Security Administration (SSA) and NIAAA - Information Exchange Pertaining to NIAAA Grantees Involved in Alcoholism Treatment

Cooperative effort between SSA and NIAAA has been taking place in FY 1974 to exchange data relating to the implementation of Title XVI of the Social Security Amendments, 1972, and the relationship to alcoholism. The Social Security Act and PL 92-603, Section 1611(e)(3), -- Supplemental Security Income, requires that an alcoholic is undergoing treatment at an approved institution to be eligible for supplemental security income.

Health Services Administration

Indian Health Service

Special Approach for the Indian Population

In 1969 an Indian Health Service Task Force on Alcoholism stated that "the majority of suicides, murders, accidental deaths, and injuries are associated with excessive drinking, as are many cases of infections, cirrhosis, and malnutrition. By far, the majority of arrests, fines, and imprisonments are the result of drinking (76 percent)." As a part of the President's message to the American Indians in July 1970, additional dollars were committed to begin development of needed special programs. These programs are carried out in cooperation with the NIAAA and have as objectives to increase public understanding and awareness of the problem; to change community attitudes; to support rehabilitation sources; to develop preventive programs for Indian youth; and to design education and training programs in the field of Indian alcoholism. The Institute's projects are designed to provide residential care, individual counseling, job placement, referral service, group therapy, Indian AA groups, recreation and self-government. The essential aspect of these projects, however, is the integration of Indian cultural patterns into the rehabiliative and learning processes by hiring Indian staff for programs, working through individual tribal mores, and emphasizing the Indians's image of himself.

The problem of alcohol abuse and alcoholism among Indian people requires excellent technical assistance in developing Indian alcoholism programs, training for Indian people, research into psycho-social variables of alcohol abuse and alcoholism among Indian people and sufficient funding, in order to deal effectively with this major health problem. The Indian Health Service and the NIAAA are in agreement on this approach together with the Indian community whose input helps clarify what the objectives should be, and who will assist in setting national policy with respect to the delivery of more effective alcoholism services to the American Indian and Alaskan Native communities.

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NATIONAL INSTITUTES OF HEALTH

National Institute of Arthritis, Metabolism, and Digestive Diseases

NIAMDD grantee Dr. Charles S. Lieber of the Mount Sinai School of Medicine, City University of New York, has produced the entire spectrum of alcoholic liver injury in baboons by prolonged administration of alcohol. Alcoholic fatty liver developed in all 13 of his animals, alcoholic hepatitis in four, and cirrhosis of the liver in two. The data suggest that a nutritious diet will not prevent development of alcoholic hepatitis and cirrhosis when excessive alcohol is consumed over a prolonged period.

The 13 baboons were fed a nutritionally adequate diet for nine months to four years, except that alcohol replaced carbohydrate calorie for calorie and accounted for 50% of the total calories. Control animals were not given alcohol.

The structure of the baboon liver, which is virtually indistinguishable from the human liver, remained unchanged in control animals. Structural changes in the liver cells of baboons fed alcohol, however, were remarkably similar to those seen in human alcoholic hepatitis and in volunteers fed alcohol. Use of this new primate model may afford the opportunity to identify the biochemical events that trigger development of alcoholic hepatitis or cirrhosis, or both, in the alcoholic fatty liver.

Another Institute grantee, Dr. Dale H. Cowan of Case Western Reserve University, has been trying to determine if blood platelets from alcoholic patients function normally and if their function correlates with their known reduced survival rate. He has found that sustained consumption of large quantities of alcohol is associated with multiple alterations in platelet function, particularly resulting in a prolonged bleeding time, and impairment of primary and secondary platelet aggregation.

Platelet function was normal before and after alcohol ingestion by five alcoholic patients; however, bleeding times were four times normal and platelet aggregation was impaired during alcohol consumption. The findings suggest that damage to platelet forerunners or platelets induced by alcohol may cause both impairment of the normal clotting process and premature destruction of platelets.

Community Services Administration

The Community Services Administration has responsibility for administering the Social Services program authorized under Titles I, IV-A, VI, X, XI, XIV and XVI of the Social Security Act, as amended in 1972.

The 1974 Social Services Amendments to the Social Security Act (P.L. 93-647) establishes a new Title XX which authorizes grants to States for Services to eligible individuals on the basis of income. Except for the Commonwealth of Puerto Rico, the Virgin Islands and Guam, Title XX supersedes all of the authorizing Titles cited above and is effective October 1, 1975.

Within the broad-spectrum of services provided to eligible individuals are those directed to preventing, solving or alleviating the problems brought on by alcoholism. It is estimated that States will expend $35,000,000 in Federal funds through this program in FY 1976 on eligible individuals for services related to alcoholism.

OFFICE OF HUMAN DEVELOPMENT

Rehabilitation Services Administration

In recent years there has been a steady increase in the number of people with alcoholism served by State rehabilitation agencies, and in FY 73 about 5% of all rehabilitations had alcoholism as their primary disability. The Rehabilitation Act of 1973 requires that priority in services be afforded severely handicapped individuals, and neither the Act nor the Federal regulations includes alcoholism within the definition of severe handicap. Therefore, it appears probable that there will be a gradual decline in the number of alcoholic individuals served by State rehabilitation agencies in the future.

Numerous special projects in alcoholism have been conducted by State rehabilitation agencies. In New Jersey, for example, the State agency works in close collaboration with private industry and organized labor in identifying and providing necessary services for employees whose jobs are endangered by alcohol abuse. Another project with a similar purpose is operated by the Wisconsin agency at De Paul Rehabilitation Hospital in Milwaukee. The Texas agency administers a project in El Paso to help the Chicano alcoholic, and another project in Dallas County to serve people being treated for alcoholism at Terrell State Hospital. Additional projects designed to serve alcoholic people are active in Alabama, Alaska, Connecticut, Florida, and Washington.

The Rehabilitation Services Administration has been operating in close cooperation with the National Institute on Alcohol Abuse and Alcoholism under the terms of a Memorandum of Agreement between the two agencies. Among their joint activities has been a national conference of the Directors of State alcoholism and State vocational rehabilitation agencies conducted in March 1973 for the purpose of stimulating cooperative planning and programming in the area of alcoholism. Efforts are also being made to foster the integration of treatment and vocational rehabilitation services for alcoholic people.

Research and Demonstration projects concerned with alcoholism have (1) developed methods of counseling, placement and follow-up of members of skid row populations; (2) conducted long-term follow-up studies of rehabilitated alcoholics; (3) studied career patterns of alcoholics to identify factors in successful vocational adjustment; (4) established a half-way house for homeless alcoholic men; (5) studied problems of alcoholic offenders; (6) developed two series of films on rehabilitation of alcoholics based on research results, one intended for public showing over television and the other series for professional training.

Also administered by the Office of Research and Demonstration is the Special Foreign Currency Program. Evaluation and reports on progressive action programs in Poland and Yugoslavia are of value to the United States and other countries where there is concern about the increasing number of alcoholics and problem drinkers. There is a greater recognition by programmers in this field that these men and women need social and psychological rehabilitation services. New projects emphasize an interdisciplinary approach to ascertain the most efficient methods of bringing about vocational rehabilitation in a community setting for alcoholic and problem drinkers. This program will be closely integrated with the domestic rehabilitation research program.

Number of Alcoholism Rehabilitations

Fiscal Year	Persons Rehabilitated	
	Total	Alcoholics
1972	326,138	14,811
1973	360,726	16,452
1974	361,138	14,800
1975	363,000	14,500
1976	332,000	13,300

Estimate Cost for Programs Serving American Indians
(Dollars in Thousands)

Health	1974	1975	1976
Indian Health			
Direct Care	95,888	113,076	99,142
Contract Care	41,028	45,913	51,081
Field Health Services	60,715	73,621	115,971
Construction	49,927	57,431	41,458
Program Management	2,999	3,062	3,347
Subtotal	250,549	293,103 1/	310,999
Other Health Services			
Health manpower	5,160	2,476	3,011
Alcoholism and general mental health	13,087	7,353	11,891
Total, health	268,796	302,932	325,901
Office of Education			
Elementary and Secondary Education	53,970	53,914	52,138
Indian Education	41,265	42,034	42,055
School Assistance in Federally affected areas	42,039	41,637	27,405
Emergency School Aid	2,236	356	356
Education for the Handicapped	635	1,395	765
Occupation, Vocational & Adult Education	14,621	10,597	8,228
Higher Education	17,165	20,818	21,593
Library Resources	1,271	1,313	665
Proposed Legislation	---	1,000	1,000
National Institute of Education	992	770	831
Total, Education Division	174,194	173,834	155,036
Public Assistance			
Maintenance Assistance	58,000	53,000	57,000
Medical Assistance	6,000	7,000	8,000
Social Services	17,000	20,000	21,000
Research	1,000	3,000	8,000
Total, SRS	82,000	83,000	94,000
Office of Human Development			
Child Development	11,349	12,500	13,000
Youth Development	200	109	---
Rehabilitation Services	3,900	4,080	4,080
Administration on Aging	1,640	1,750	2,000
Native American Program	30,000	32,000	32,000
Total, OHD	47,089	50,439	51,080
Total, DHEW	572,079	610,205	626,017

1/ Includes 9,455 thousands supplemental pay raise

HEALTH SERVICES ADMINISTRATION
Indian Health Service

The Indian Health Service (IHS) is a component of the Department of Health, Education, and Welfare's Health Services Administration (HSA), which is working to improve health services and promote better health for all Americans. The responsibility of the Indian Health Service is to 469,000 American Indians belonging to more than 250 tribes and 38,000 Natives living in 300 Alaska villages.

The problems that these citizens encounter in preserving health and obtaining needed health care exceed those of most other Americans. The goal of the Indian Health Service is to raise the health of the Indian and Alaska Native people to the highest possible level and assist them in every way possible to achieve a better quality of life. Interacting with other HSA activities in many mutually beneficial ways, and with public and private agencies, the Indian Health Service is developing innovative ways to dispense health services, utilize manpower, stimulate consumer participation and apply resources. In this effort, the Indian Health Service has three major objectives:

To assist Indian tribes in developing their capacity to man and manage their programs through activities such as health management training, technical assistance, and human resource development and provide every opportunity for tribes to assume administrative authority through contracts and delegation.

To act as the Indians' and Alaska Natives' advocate in the health field to generate other interests and resources which can be utilized.

To deliver the best possible comprehensive health services, including hospital and ambulatory medical care, preventive and rehabilitative services, and to develop or improve community and individual water and sanitation facilities and other environmental factors affecting good health.

ORGANIZATION OF THE SERVICES

Headquarters - The staff of the Indian Health Service headquarters includes health and administrative professionals and clerical staff who support overall operations and provide advice and guidance to field offices. The organizational structure and activities of the staff are geared to serve as a resource for field staff personnel in management, administrative services and various health disciplines.

Field Administration - The field service is divided administratively into eight area offices and three program operations. Each area and program office is responsible for operating the health program within its designated geographical area, utilizing Indian Health Service or contract facilities, to provide comprehensive health care services.

Service Units - Areas are broken down into service units, to facilitate operation of the program. A service unit is the basic health organization in the Indian Health Service program, just as a county or city health department is the basic health organization in a State health department. These are defined areas, usually centered around a single Federal reservation in the continental United States, or a population concentration in Alaska. A few units cover a number of small reservations; some large reservations are divided into a number of units. The Navajo Reservation, which covers 24,000 square miles in three States and has a service population of approximately 98,000 is divided into eight service units. Most service units encompass a hospital or health center staffed by competent teams.

Research and Training - The Office of Research and Development in Tucson, Arizona, combines the Service's Training and Health Program Systems Centers, and the Papago Reservation health programs. There, new methods and techniques for health care delivery, reporting systems, and manpower resources and utilization are being developed to provide new insights into the improvement of health care planning, programming, implementation, and evaluation.

THE INDIAN HEALTH SERVICE COMPREHENSIVE HEALTH PROGRAM

The comprehensive health services program is designed to cope with the observed and stated health needs of Indian people and Alaska Natives. It provides a broad scope of primary care and preventive and rehabilitative services through a system of expanding facilities, manpower, and health programs. Planning and implementation of all phases of the health services program reflect the cooperative efforts of a highly proficient health and administrative professional staff and consumer representation of the Indian people and Alaska Natives. Tribal health boards, advisory boards, community development activities, Indian training and manpower recruitment programs, and local health activities all help to assure consumer input. These activities and others provided through tribal contracts provide the resources to enable Indians to man and manage their own program.

In recent years a number of private, State, and other Federal governmental health resources have been mobilized to assist Indian Health Service in its mission to improve the health status of Indian people and Alaska Natives. These include programs of other constituencies of the Department of Health, Education, and Welfare, the Department of Housing and Urban Development, the Office of Economic Opportunity, the Bureau of Indian Affairs, the Department of Labor, and the National Council on Indian Opportunity; a number of States; individual Indian tribes and intertribal groups; and private and voluntary Indian interest groups.

FACILITIES AND SERVICES

The program is carried out through a system of 51 hospitals, ranging in size from 6 to 191 beds, 3 of which are referral, teaching and research centers; 86 health centers, including 26 school health centers; and more than 300 health stations and satellite field health clinics. Additional medical and dental clinics are held at appointed locations on a regular schedule, daily, weekly, or monthly. Special clinics are held intermittently, as needed. Contracts are also maintained with over 300 private or community hospitals, more than 18 State and local health departments, and some 1,600 physicians, dentists and other health specialist to provide hospitalization and specialized diagnostic and therapeutic services. The contract program is used in locations where there is no Indian Health Service facility, health professional, or alternate resource to provide the required service.

Most service units have a hospital or health center and a number of satellite clinics providing inpatient care and outpatient services through preventive and curative clinics. Special services include prenatal, postnatal, well-baby, family planning, diabetes, heart disease, trachoma, tuberculosis and immunization programs. Added services are provided by public health nurses, community health medics (physician assistants), tribally employed community health representatives, nutritionists, health educators, mental health workers, social workers and sanitarians who are engaged in home visits, in follow-ups on discharged tuberculosis patients and newborns and mothers, in health education conferences and in environmental health endeavors.

School health programs are conducted in boarding and day schools operated by the Bureau of Indian Affairs, Department of the Interior, and public schools on reservations.

Dental services are provided at hospitals, health centers and health stations, and in mobile dental units. In some locations where the Public Health Service has no facilities, care is provided under contract with dentists in private practice. In Alaska, dental teams travel to remote villages by charter plane taking equipment with them.

Dental care for persons under 17 years of age is given priority, a policy that began in 1968 when the DMF rate (decayed, missing and filled teeth) for Indian children showed a decline for the first time in 13 years. Expanded resources, increased efficiency and the addition of dental assistants have contributed to a steadily decreasing DMF rate since then. Reaching all children and providing care for an increasing number of adults are continuing aims.

Environmental health services provided under the direction of Indian Health Service sanitarians are an integral part of the Indian Health Service total comprehensive health program. In concert with the health staff, the sanitarian works to combat unhealthy environmental conditions and practices, poor and crowded housing, lack of safe water supplies and inadequate waste disposal facilities, all of which contribute to a high rate of infectious diseases.

NEW DIRECTIONS

Consumer Involvement - The increasing involvement of Indian people, especially in leadership roles, has been one of the most significant developments in recent years. A Division of Indian Community Development has been established to make the Indian Health Service more responsive to the health needs of Indian people and their changing role in managing their own health programs.

The National Intertribal Health Board of 12 Indian leaders representing all areas and program offices, Indian health boards and other committees, is helping to develop policy, determine health needs, establish priorities and allocate resources at each administrative level throughout the Indian Health Service. In addition to health programs, social, economic and other aspects of better health and quality of life are being emphasized. Existing problems are being identified and new ideas, resources and health related programs are being developed to bear upon the problems of health services delivery. The involvement and subsequent contributions of Indian groups have led to changes in health services delivery methods and more effective adaptations of health services in a number of Indian Health Service locations.

NEW COMMUNITY INITIATIVE

Indian and Alaska Native people have taken the initiative to develop and operate a variety of local programs to meet their most critical needs. Many individuals have taken leadership training in health affairs which they are utilizing in their respective reservations and communities. The effectiveness of local action has been demonstrated in direct community health services activities such as programs in nutrition, accident prevention, alcoholism control, suicide prevention, mental health, improved housing and other areas of community action and economic development.

Indian self-determination is rapidly emerging as a working concept. It is uniquely evident in California and the Southeastern United States where Indians are managing their own health affairs.

The California Rural Indian Health Board, under agreement with the Indian Health Service, is arranging the delivery of a variety of health services to Indians living in 16 project areas composed of 34 counties. The United Southeastern Tribes Intertribal Council is managing health care for Indians residing in Mississippi, North Carolina, Florida, and Louisiana, through Indian Health Service and contract facilities in those States.

SPECIAL PROGRAMS

The level of health today among Indians and Alaska Natives is in many respects similar to that of the general population about a generation ago. Physicians encounter a greater variety of clinical conditions in Indian Health Service facilities then in other health programs in the country. Special health needs are met in varied ways with activities keyed to removing the source of the problem.

MENTAL HEALTH

As the Indian people have been caught more and more in the conflict between their old, traditional cultural and the demands of modern American society, mental health problems have increased. The seriousness of mental health problems among Indians and Alaska Natives is demonstrated in age adjusted suicide rates which are 1.9 times as high as that of all races and a homicide rate 3.1 times as high. Indian deaths from alcoholism, alcoholic psychosis, or cirrhosis with alcoholism are 6.2 times as high as in the general population.

Emotional problems and behavioral disorders are frequent among Indian children in their struggle for identity and achievement of self-sufficiency in a new social set-up. There is increasing need for the mental health component in child guidance and counseling, and for the development of new and effective methods to prevent further trauma to the growing child.

As of this fiscal year, professional mental health teams are working in all Indian Health Service areas. A pilot inpatient mental health program has been introduced, a model dormitory project is being conducted, and training of Indians as mental health workers and technicians has been expanded.

The Indians themselves have undertaken innumerable projects especially in alcoholism control.

OTITIS MEDIA

Otitis media has always been a serious health problem among Indians and Alaska Natives and in the last decade has replaced tuberculosis as a major health problem inflicting serious and often permanent damage.

The extreme prevalence of the disease with the accompanying demands for prolonged treatment, curative and restorative surgery and rehabilitation created a workload that was impossible to meet out of regular program resources. In 1970 Congress appropriated additional funds especially for an otitis media program, making it possible for the Indian Health Service to institute the kind of program necessary to bring this serious problem under control.

NUTRITION

Mild and moderately severe nutritional deficiencies are relatively common among Indians and Alaska Natives, especially in infants and preschool children and women in the child-bearing years of 15-44. Malnutrition, a problem in itself, also is a contributing or complicating factor in a wide variety of other health problems and illnesses. To help improve the nutritional status of Indians and Alaska Natives, the Indian Health Service conducts a family-centered nutrition services program of intensive education, adapting proper principles to the food habits and cultural practices of Indians and Alaska Natives.

Additionally, through the nutrition program of the Center for Disease Control, four Indian tribes and the Alaska Federation of Natives have grants to conduct demonstration programs to better nutritional health by improving food supplies, training Indian workers, increasing participation in food assistance programs and providing practical information to Indian and Alaska Native people.

MATERNAL AND CHILD CARE

The high rate of illness and death among infants in the first year of life is met with emphasis on early prenatal care for the mother and continuing care after she and the baby leave the hospital. Health education activities are conducted to teach the mother proper ways to feed, bathe and care for her family within the often limited resources of her home, how to recognize illness, and why it is important to observe good health habits and make regular visits to the clinic.

A nurse midwife program was recently introduced to reach mothers living in isolated areas. The first such program was initiated in Alaska in 1970 to expand and improve the health care of mothers and children and to demonstrate the role a nurse midwife can play in reducing maternal and infant deaths. Similar programs have since been instituted in Shiprock, New Mexico, and in the Fort Defiance, Keams Canyon and Chinle Service Units in Arizona. Nurse midwifery services are also being developed in Pine Ridge, South Dakota, and Lawton, Oklahoma. In cooperation with the Schools of Nursing, University of Utah and Johns Hopkins University, the program is being expanded to other areas.

Center for Disease Control

Venereal Disease Program

Venereal disease control services are provided to American Indians, Eskimos and Aleuts through venereal disease project grants awarded to State and local health departments. Approximately one-half of the 800,000 Indians living in the United States are eligible for health services provided through Indian Health Service facilities located in 24 States. In each of these States, venereal disease control efforts and services are coordinated between the State Health Department and individual Indian Health Service facilities.

In late FY 1972, as the national gonorrhea control program was being implemented, VDCD staff visited each of eight Indian Health Service Area Directors with representatives of the concerned State and local health departments. These meetings established the agreements necessary for supporting the extension of venereal disease control services in Indian Health Service facilities. Primarily, the resources in support of program expansion have been provided by Federal VD control grants through State Health Departments, with the Indian Health Service providing clinical services.

The major focus in program expansion has been to implement gonorrhea culture screening services. The number of cultures obtained from women increased from 38,443 in FY 1973 to 49,274 during FY 1974. The percentage positive during FY 1974 remained relatively high at 4.9 percent.

In addition to screening activities, syphilis and gonorrhea casefinding services are provided to infected individuals in an effort to interrupt the transmission of disease. Systems also exist to ensure that individuals with reactive serologic tests for syphilis receive adequate medical attention.

The VD control program which is the most complex in terms of both the level of disease incidence and the coordination effort required is in the Navajo Area. The program involves four States and three DHEW Regions. Resources for the control program in the Navajo Area are furnished by the States of Arizona and New Mexico. Federal grant support is furnished primarily through New Mexico. In addition to these resource inputs, the Indian Health Service recently awarded a contract to the Navajo Tribal Council to furnish outreach services in support of the VD control program.

VD Update for IHS Physicians

On September 9-10, 1974, a VD Update Course was presented to approximately 40 Indian Health Service clinicians at Gallup, New Mexico. The aim of the course was to provide an overview of venereal disease, particularly for the younger physicians, and to discuss specific problems encountered among Indian populations.

The course consisted of a series of 1-2 hour lecture/discussion periods, with an algorithmic approaxh, i.e., patient or physicain problems were considered and a systematic approach was used to solve these problems. The topics included urethral discharge, vaginal discharge, penile lesions, positive syphilis serology, skin rashes and epidemiologic treatment.

This course has been modified and expanded to three days and has been offered to any other groups of IHS phisicians in the United States.

Immunization Programs

During 1974 immunization assessment activities, supported by immunization project grants were conducted by State health agencies on selected Indian Reservations. Special immunization clinics were conducted where immunity levels were determined to be low. Immunization project grant vaccine was provided upon request to the Indian Health Service for use in ongoing immunization clinics.

CDC assisted State health agencies and the Indian Health Service in Arizona, New Mexico, Utah, and Colorado in investigating outbreaks of the Navajo, Hopi and UTE Reservations. Additional outbreak control activities were conducted on Reservations in the State of Washington where diphtheria was also reported.

Tuberculosis

Tuberculosis in American Indians, although not an enormous problem numerically, is strikingly disproportionate in terms of morbidity rates as compared with the general population. In certain States (Oklahoma, South Dakota, North Dakota, Montana, Wyoming, Utah, Arizona and Alaska), tuberculosis cases constitute a sizable percentage of the total case rate. For instance, in 1973 almost half the cases in New Mexico were in American Indians. The Public Health Service has been involved in tuberculosis control in the State of Alaska for many years. Many of the early controlled trials of isoniazid preventive treatment were done in Alaska and Center for Disease Control physicians and nurses have worked in the Alaska tuberculosis programs intermittently since the mid 1950's. Because of the striking success in reducing tuberculosis morbidity in the Alaskan native population (infection rate is entering school children down from approximately 90% to less than 1% in the last 15 years), it was felt that efforts needed to be made to achieve similar success in other Indian Health Service Areas.

Since 1968, 10 medical officers have been assigned as tuberculosis controllers to Indian Health Service Area Offices in Aberdeen, Window Rock, Albuquerque, Phoenix, and Anchorage. These physicians have been involved in providing clinical consultation, training, planning, and evaluation of tuberculosis control activities. Since 1971, 495 nurses, physicians, pharmacists, and community health workers from the Indian Health Service have attended "Tuberculosis Today!" courses in Gallup, Aberdeen, Window Rock, Albuquerque, and Phoenix. Two hunderd and three have attended during the last year.

Center policies and recommendations, principles of program evaluation, and data collection have been introduced to these Areas as a result of these assignments. Since we began our close working relationship with the Indian Health Service, a number of changes have taken place. Indian patients today are treated on the reservation, either in service unit hospitals or in some cases on an ambulatory basis at the local clinics. For the most part costly and unnecessary inpatient facilities for tuberculosis care only have been eliminated.

Tuberculosis registers have been reviewed and cases no longer requiring service have been eliminated. As a result of reducing the caseload and training of workers, the results of ambulatory treatment have been significantly improved. One example is on the Navajo reservation where the number of new active cases has declined from 184 to 110 between 1970 and 1973. In 1970, 30% of active cases were in the hospital, 35% were at home on drugs, and 35% were at home with status of drug therapy uncertain. In 1973, only 15% of active cases were in hospitals, 75% were at home on drugs, and only 10% were at home with drug

therapy uncertain. Also, among Navajo Indians the proportion of children (5-9 years old) found to be positive tuberculin test reactors dropped from 9% in 1962 to 2.7% in 1970. In 1973, 0.4% of children under 5 years of age were positive to the tuberculin test, approaching the national infection rate for this age group.

Future planning for tuberculosis control in the Indian population is based on the concept that clinical services should be provided in the service units by Indian Health Service personnel, but tuberculosis control services (epidemiology, planning, evaluation, data collection, etc.) should be performed by the State Tuberculosis Control office. Excellent relationships have been developed between the Indian Health Service, Center for Disease Control and the respective State health offices. All of these groups are optimistic that tuberculosis incidence in the Indian population can be significantly reduced.

HEALTH RESOURCES ADMINISTRATION

Programs Benefiting American Indians in the Bureau of Health Resources Development

Health Manpower programs for the specific support and development of American Indians do not exist apart from the overall commitment to improve minority participation in health occupations, health care, and health services delivery. This commitment is expressed through the special provisions for minority assistance contained in the principal health manpower legislative authorities of the Public Health Service Act: Title III, Title VII, and Title VIII.

The authorities which provide for minority assistance seek to achieve these objectives for American Indians (as for other minorities): (1) encourage education institutions to develop and expand educational opportunities for Indians; (2) increase the numbers of Indians in health occupations; (3) provide for the advancement of Indians in health careers; and (4) increase and improve the health services provided to Indian communities.

AMERICAN INDIANS

Since its establishment in September 1973, the National Institute on Drug Abuse (NIDA) has become increasingly aware of and involved in the problem of drug abuse among American Indians. In this brief eighteen month period the Institute's commitment to this particular area of drug abuse has increased from the support of fifteen projects at a total federal cost of $486,000 to twenty-five projects involving Indians totaling over $1.5 million with another $300,000 designated for new projects before the end of FY 1975. In addition, the scope of NIDA's efforts has grown from supporting simply prevention and treatment projects to more recent efforts in training, demonstration, and research. At the same time, NIDA has attempted to ensure that a coordinated approach be maintained by consulting with federal agencies already involved with relevant services to Indians as well as with various Indian associations themselves. This method will soon be formalized by the establishment of a collaborative consultant group composed of individuals representing such agencies and organizations as the Indian Health Service, the National Tribal Chairmen's Association, and the National Indian Board on Alcoholism and Drug Abuse. The FY 1976 budget will allow NIDA to continue this program at a level of effort consistent with FY 1975. Examples of specific NIDA projects in this area are summarized below.

Treatment Services Programs

NIDA currently supports fourteen treatment projects in which Indians are provided assistance in dealing with their drug abuse problems. A grant with the Red Lake Tribal Council in Red Lake, Minnesota provides services exclusively to members of the tribe at a total annual federal cost of approximately $200,000 with a treatment capacity for 150 patients. This outpatient drug free program provides the following additional services: (a) individual and group counseling; (b) remedial education; (c) preventive services with families and school groups; (d) job training and placement; and (e) cultural and recreational programs. The program also operates four drug awareness centers for teenagers. A second program in Flagstaff, Arizona has four major Indian clinic affiliates including the Apache Tribal Guidance Clinic and the Navajo County Guidance Clinic. Services available through this program include crisis intervention, detoxification, inpatient and aftercare as well as family, individual and group therapeutic services. These clinics are supported at a federal cost of about $110,000 for 60 patients.

Demonstration Programs

The uniqueness of the Indian situation in the American society has led the Institute to explore new and innovative methods for addressing their drug abuse treatment needs. The Morning Star Project in Billings, Montana, supported at an annual federal cost of $422,000, provides a prime example of this approach. This project is attempting to effect the integration of a treatment regimen with Indian culture and philosophy, the basic assumption being that the drug addicted Indian can best be rehabilitated by strengthening his connection with his culture, making use of its spiritual values, and enhancing his sense of identity. The treatment program itself is basically a drug-free therapeutic community staffed almost entirely by Indians. The inadequacy of many present alcoholism and drug abuse treatment programs involving Indians is attributed to the fact that they separate him from his culture. Another example is a $190,000 grant with the Western Nevada Indian Health Board in Stewart, Nevada, which is conducting a two-year program in the Stewart Indian School to demonstrate that increased personal and cultural awareness in Indian youth will result in a lifestyle in which the use of drugs will be avoided. The program

utilizes experienced adult Indian counselors and trained student-peer counselors to assist clients in increasing personal and cultural awareness and in recognizing constructive alternatives for dealing with social and emotional needs.

Prevention Programs

While service and demonstration projects are attempting to address the treatment needs of those already involved with drug abuse, the Institute is concomitantly supporting projects specifically aimed at preventing further abuse among Indians. A three year grant for an estimated total support of $567,000 with the Small Tribes Organization of Western Washington, Inc. (STOWW) is one such program. This project provides intensive drug abuse education to the STOWW tribes, including counseling to individuals and parents, conducting rap sessions and self-awareness groups with high risk personnel, and suggesting viable alternatives to the inappropriate use of mind altering drugs. Volunteer Indian staff are trained at the Skokomish and Nooksack Centers and, as their training progresses, the professionals gradually phase out. A similar grant with Miccosukee Tribe in Florida, funded for three years for approximately $147,000, attempts to motivate members of the tribe to develop positive and constructive programs for youth development and cultural enrichment in order to preclude the possibility of turning to drugs. Special emphasis is given to providing education regarding the effects of drugs, to increasing awareness as to the traditions and lore of the tribe, and to developing active youth involvement in the running of the program.

Training Programs

In order to develop a manpower pool of Indians trained to treat drug abusers within their population, the Institute has worked with its prime contractor, Youth Projects, Inc./National Free Clinic Council, to establish training subcontracts with Indian groups. The Keweena Bay Indian Community Health Service Center in Baraba, Michigan and the American Indian Free Clinic in Compton, California have been supported as subcontracts in this program for the last three years at a total federal cost of $127,000. Each subcontractor has developed its own training methodology to meet the specific needs of the drug abuse problem in their locality, and both send their trainers to the NIDA funded Regional Training Centers to develop approaches and ideas for the best training techniques and curricula for their individual programs.

Research Programs

In an attempt to generate a better overall understanding of the drug abuse phenomenon among our Indian population, the Institute is funding a joint research grant with Colorado State University and the Indian Health Service at a total cost of $267,000. The overall purpose of the project is to obtain prevalence data on drug abuse and cognitive and attitudinal items on drug knowledge and motivation from Indian adolescents. The investigators have chosen two sampling units within the nine Indian Health Service regions based on the recommendation of the Tribal Councils in the proposed areas. The primary data gathering instrument is a self-administered questionaire which includes items not only on drug use and knowledge of drugs, but also on preception of a wide range of social and psychological problems. While the study is designed to focus on those adolescents within the school system, an attempt is being made to survey school dropouts. Supervision of the administration of the instrument is by trained Indian Health service workers, rather than by members of the school system.

National Institute of Mental Health

AMERICAN INDIAN

The American Indian has been characterized as the most impoverished and deprived group in our nation, in terms of employment, income, education, health and housing.

In contrast to a slow growth rate of 13% of the American population in the past decade, the American Indian population grew by 50% in the 1960's. The 1970 Census reported 827,000 American Indian and Alaskan Natives in the U.S. The Census reported that in comparison to 14% of all American families, 40% of American Indian families live on income levels below the poverty level. The median age of the American Indian in 1970 was 20 -- eight years younger than the national median. Almost 50% of American Indians are living in urban areas.

Along with the many other statistical indices of the severe plight of the American Indian, indicators of extreme and increasing psychological and emotional distress are present. The suicide rate for American Indian adolescents is four times that of the general population, with a rate 20 times the national average on at least one reservation. The 1973 overall U.S. crude suicide rate was 12.0 per 100,000 in contrast to the American Indian overall crude rate of 19.4 per 100,000. Other indicators of the significant mental health need are the extraordinary incidence of alcoholism, glue sniffing and school drop-outs.

There is a clearly documented need for mental health services especially designed to meet the unique requirements of the American Indian populations. The resolution of this problem is made difficult by a severe shortage of American Indian mental health professionals. There are, for example, only seven known American Indian psychiatrists.

Research

In November 1972 the NIMH Center for Minority Group Mental Health Programs, assembled, at a National Conference on Indian Mental Health, a representative group of American Indians concerned with mental health issues. A major concern expressed by this group was the need for research designed and implemented by American Indians which is directly related to American Indian mental health problems. In direct response to the stated need, NIMH provided funds in FY 1975 to the National Tribal Chairmen's Association and the University of Oregon to establish a National Mental Health Research and Development Center for American Indians and Alaskan Natives. The principal objectives of the Center include:

1. Conduct research which has been identified as a high priority by American Indians, Alaskan Natives, mental health/behavioral and social science scholars, and the Center's National Advisory Committee;

2. Provision of a research preceptorship for American Indians and Alaskan Natives with guidance and supervision by members of the same racial groups;

3. Monitoring and coordination of research projects relating to American Indians/Alaskan Natives, (i.e., projects which are being conducted by other institutions, agencies and programs);

4. Affiliation and collaboration with other research programs focused on studies of American Indian/Alaskan Natives;

5. Provision of technical assistance to American Indians/Alaskan Natives in the design of research and/or identification of resources for support. Upon request, technical assistance would be provided to non-American Indians/Alaskan Natives in the design, evaluation and implementation of research pertaining to American Indians/Alaskan Natives;

6. Collection, storage, retrieval and dissemination of unique mental health and social science data pertaining to American Indians/Alaskan Natives;

7. Identification of model mental health research and development resources and programs relating to delivery of mental health services, manpower development and research for American Indians/Alaskan Natives;

8. Through the Center's National Advisory Committee, Board of Directors of the National Tribal Chairmen's Association, and other American Indian/Alaskan Native organizations and individuals, identification of needs and periodic evaluation of the programmatic directions of the Center.

Priority research areas will include development of culturally sensitive models for the delivery of mental health services to American Indians/Alaskan Natives; identification of factors in high incidence of emotional disturbances among American Indian children in Indian boarding schools; development of a theoretical model for contrasting and/or evaluating the effectiveness of the medicine men and physicians as practitioners for given conditions in selected socio-cultural contexts; assessment of mental health needs of urban, inner-city and reservation American Indians and Alaskan Natives; foster child placement programs (impact on Native belief and value systems, socialization patterns, and quality of adjustment); and effects of non-Indian testing and counseling programs.

Service Delivery and Manpower Development

By December 1974 the NIMH had made construction and/or staffing grants to community mental health centers which are to serve 60 Indian reservations in 17 states. The 39 centers have all or part of the reservations in their

catchment areas. A substantial number of the centers have established full-time satellite offices so services are closer to people's homes. An effort is made, as in the Four Corners Mental Health Center in Utah, to employ Indians on their staffs.

The absence of American Indian mental health workers represents a severe handicap to the effective provision of services to American Indian populations. The NIMH has attempted to bridge this American Indian manpower gap through the funding of special social worker training projects in Arizona, Florida, Oklahoma, Oregon, Texas and Utah. American Indian mental health workers have been trained in: California, Colorado, Minnesota, Montana, New Mexico, New York, North Dakota, Oregon and South Dakota. Also, a unique nurses training project was initiated in North Dakota.

THE SCOPE OF THE PROBLEM

Alcohol abuse and alcoholism are not new problems among American Indians and Alaskan Natives. Historians report that early American frontiersmen, trappers and traders offered spirituous beverages to Indians as a gesture of friendship. Later, with a different motive, the white man was known to offer alcohol to Indians while treaties and land rights were being negotiated. Widespread alcohol abuse was responsible for growing dissension, violence and poor judgement among Indian people and in 1832, at the request of the Indian people, Congress passed legislation prohibiting liquor traffic to and among Indians. Over the years it became apparent that the law was discriminatory and it was finally repealed in 1953.

The 1832 law marked the first acknowledgement on the part of the Federal government that alcohol abuse among Indians was a major social and health problem deserving of national attention. Federal concern over the problems of alcohol abuse, was, however, until recent years, eclipsed by the severe problems of health, housing, sanitation, education and chronic unemployment which became the fate of Indian people after they were relocated on Federal reservations.

When Federal agencies such as the Bureau of Indian Affairs (BIA), and later, the Indian Health Services (IHS), first began assisting the Indians with health and welfare programs, they did not give high priority to the problem of alcohol abuse. These two agencies, which are still actively committed to administering programs for the benefit of Indian people, have both added alcoholism efforts in recent years.

However, it was not until the National Institute on Alcohol Abuse and Alcoholism (NIAAA) in a special report to Congress in 1971 named "reducing alcoholism among American Indians" as one of its six priority goals that a concentrated effort, supported by substantial funds, was launched by the Federal government against alcoholism among Native Americans.

In NIAAA's first year of operations, 1971, it found the American Indian and Alaskan Native peoples to be the most deprived and isolated group of people in our nation - by any measure the most neglected, the most misunderstood and the most repressed minority of our time. But NIAAA also found Indian people increasingly concerned about their alcohol abuse and alcoholism problems and ready to put into practice their own prevention, education and service programs if given the opportunity. NIAAA decided it must establish a common middle ground policy between a Federal hands-off attitude and excessive paternalism - a policy which stressed first: the central role Native Americans must play in the planning, development, staffing and administration of their own programs and second: the establishment of an Indian Desk in the Institute, staffed by an Indian and third, an all Indian review group to review Indian project grant applications.

The new Federal commitment, in concert with the Indians own determination to combat their alcohol abuse problems, finally made it possible for alcoholism treatment, education, research, training and prevention efforts to be undertaken. Years of neglect and festering sociocultural problems, however, had compounded the problem of alcohol abuse among the American Indians and Alaskan Native population.

NIAAA found the incidence of Indian alcoholism to be at an epidemic level, with the rate estimated to be at least two times the national average and on many reservations from twenty five to fifty percent of the population. Widespread use of alcohol occured among Indian youth as young as 8 or 9 years of age. Excessive drinking weighed heavily in suicides, homicides, criminal acts, traffic accidents and acts of violence committed by Native Americans. Seventy five percent of all suicides among Native Americans were alcohol related, a rate exceeding that of the general population two or three times over. The three fastest rising causes of death among Native Americans, in order of frequency, were cirrhosis of the liver, suicide and homicide - all three linked to alcoholism. In terms of wreaking havoc among family life the effects of alcohol were incalculable.

Alcohol abuse and alcoholism among Native American individuals, families and communities was found to be inextricably interwoven into all aspects of their lives. Their problems with alcohol could not be disassociated from the pervasive stresses of their life : migrations from their Tribal lands to a non-Indian community - racial and ethnic prejudice - health impairment - chronic unemployment or marginal economic status at below national poverty levels - outside interference by non-Indian social agencies in family and community affairs - and lack of control in their own community over the education of their children, law enforcement, religious institutions and health and welfare resources.

The NIAAA has recognized the stresses and complexity of Indian life and of their problems with alcohol abuse and alcoholism. It has initiated projects and activities with other Federal and State agencies concerned with Native Americans. It has started action programs in treatment/ rehabilitation to meet the immediate needs for help while undertaking programs in training, research and prevention. While much remains to be done NIAAA feels great strides have been taken toward accomplishing its 1971 stated goal of "reducing alcoholism among American Indians."

PUBLIC HEALTH SERVICE

The National Institute on Alcohol Abuse and Alcoholism

Special Approach for the Indian Population

In 1969 an Indian Health Service Task Force on Alcoholism stated that "the majority of suicides, murders, accidental deaths, and injuries are associated with excessive drinking, as are many cases of infections, cirrhosis, and malnutrition. By far, the majority of arrests, fines, and imprisonments are the result of drinking (76 percent)." As a part of the President's message to the American Indians in July 1970, additional dollars were committed to begin development of needed special programs. These programs are carried out in cooperation with the NIAAA and have as objectives to increase public understanding and awareness of the problem; to change community attitudes; to support rehabilitation sources; to develop preventive programs for Indian youth; and to design education and training programs in the field of Indian alcoholism. The Institute's projects are designed to provide residential care, individual counseling, job placement, referral service, group therapy, Indian AA groups, recreation and self-government. The essential aspect of these projects, however, is the integration of Indian cultural patterns into the rehabilitative and learning processes by hiring Indian staff for programs, working through individual tribal mores, and emphasizing the Indian's image of himself.

The problem of alcohol abuse and alcoholism among Indian people requires intensive and specialized technical assistance in developing Indian alcoholism programs, training for Indian people, research into psycho-social variables of alcohol abuse and alcoholism among Indian people, and sufficient funding in order to deal effectively with this major health problem. The Indian Health Service and the NIAAA are in agreement on this approach together with the Indian community whose input helps clarify what the objectives should be and who will assist in setting national policy with respect to the delivery of more effective alcoholism services to the American Indian and Alaskan Native communities.

Division of Special Treatment and Rehabilitation Programs

Special Projects: American Indian and Alaskan Native Programs

	American Indian Projects			Alaskan Native Mini-grant Projects	
	#	Amount		#	Amount
FY 71	12	$750,000			
FY 72	45	3,341,726			
FY 73	97	6,498,000		44	473,000
FY 74	124	12,486,000		119	1,179,000
FY 75 Est.	71	7,458,000	1/	1	10,000
FY 76 Est.	60	7,879,000			

1/ Based on the 1975 Rescission Budget. Under the appropriation, approximately $2.2 million more would be obligated for new Indian projects, as well as renewal support for 34 Indian projects ($2.6 million).

The purpose of the American Indian and Alaskan Native Program of the NIAAA Division of Special Treatment and Rehabilitation Programs is to assist Native Americans, local communities, states and other branches of the Federal Government concerned with American Indians and Alaskan Natives in providing the best available alcohol abuse and alcoholism treatment and rehabilitation services.

The Division's basic method of approach to accomplish this purpose has been the early and continuous support of the concept of Native American self-determination and control. From its inception the Division established an Indian Desk with an Indian experienced in Native American alcoholism as its Chief, an all Native American grant review committee, and program guidelines and criteria which stressed Native American development and control of services. Simultaneously, the Division has worked actively and cooperatively with the growing movement for more mutual inter-tribal cooperative ventures (Pan-Indianism) as it related to the problem of Native American alcoholism. NIAAA has recognized and works with the National Indian Board on Alcoholism and Drug Abuse.

The Division further adopted an approach which seeks to reduce communication barriers between the Indians and the Federal bureauracy. The Indian Desk and its Chief were delegated responsibility and authority to serve as the focal point for Native American concerns and interests in alcoholism. DHEW procedures and forms were followed but were simplified and made more accomodating to assist the development, start-up and operation of services.

The Division has also worked cooperatively with other Federal agencies dealing with Native American alcoholism to promote more effective utilization of existing resources and in the shaping of more effective national policies regarding Native American alcoholism. An example is the pending NIAAA-IHS Memorandum of Agreement by which NIAAA and IHS will work closely together to develop more effective alcohol services and to maximize existing resources.

The Division has carried out its basic methods of approach at the community level, supporting Native Americans' ideas of programming and services which represent their own organization, staff and control: programs designed to provide a variety of services which may include residential care for problem drinkers, individual counseling, job placement, referral services, group therapy, Indian AA groups, didactic lectures, work therapy, recreation, self-government and cultural support activities, public education, training of Indian people and development of community services.

Accomplishments

Since their inception, the Indian alcoholism programs have had a significant impact upon the attitude of Indian people toward drinking - the first vital step in recovery. Urban Indians and Indian tribes living on reservations have gained valuable knowledge about alcohol abuse and are now viewing alcoholism as a major social, cultural, and economic problem. Other alcoholism programs without Federal funds are being developed, and community resources are being organized in a concerted effort to meet the needs of Indian people afflicted by alcoholism. The following are examples of the results achieved by our alcoholism programs:

1. The 124 Indian alcoholism programs serve about 150 clients and family members per year, per community.

2. 50% of our Indian alcoholism program clients improve and become productive citizens - 10% of these become sober - 40% change drinking patterns for the better (family relationships are improved).

3. 15-20% get jobs through the programs - this is especially important with exceedingly high rates of Indian unemployment.

4. Another 15 - 20% of clients go off welfare as a result of program activities reuniting families and assisting them in better utilization of their resources.

5. The Indian programs are reaching out to Indians in Federal, State and local jails to get parolees with alcohol problems into treatment after release. To date, the Indian recidivism rate - about 85% - is being reduced 25%. (The Indian criminal recidivism rate is the highest in the country).

6. Prior to NIAAA efforts, Indians shunned A.A.; through the Institute supported activities, however, about 100 Indian A.A. groups have been established.

7. About 50% of Indians entering NIAAA programs are now self-referrals, whereas, in 1971 the rate was near zero. This is the result of progress made toward changing the Indian's attitude toward drinking.

8. Entire Indian communities and tribes have gained knowledge about alcoholism and its problems and, as a result, community resources have organized in a concerted effort to meet the needs.

9. In the area of prevention, during fiscal year 1974, the Division explored with tribal leaders and medicine men aspects of the Indian culture which may be useful in providing alternatives to excessive drinking. In fiscal year 1973, the Division sponsored an alcohol education program in Oregon run by Indian students in a residential school. During fiscal year 1974, the NIAAA sponsored three such programs in addition to the one mentioned above.

10. Almost every major city and reservation with a large Native American population in the U.S. and in 172 Alaskan Native villages has a Native American developed and operated alcoholism progrram.

11. The development and operation of our programs has helped change public agencies' and public attitudes about Native Americans and their use of alcohol. A number of common misconceptions and stereotypes are beginning to be changed - such as "Indians Cannot Hold Their Liquor," "All Indians are Alike" - with
(a) increasing evidence that alcohol usage varies widely among Indian people,
(b) that alcohol can also be associated with beneficial effects in the lives of some Indian people
(c) that such difficulties among Indian people as suicides, violence, arrest rates now associated with alcohol are not due solely to alcohol abuse but also in part to intercultural problems
(d) that considerable differences exist among groups of Indian people regarding rates of various alcohol related events
(e) and, most important of all - that Indian people with alcohol problems are not hopeless, but can benefit from treatment. As the NIAAA Indian and Alaskan Native alcohol programs have grown in number and impact, as Native Americans have become active in the planning and staffing of these programs, increasing evidence from our reporting system and from the field, indicate that the previous trend that "Indians With Alcohol Problems are Hopeless" is being reversed.

DIVISION OF PREVENTION

The goals and policies developed by the Division of Prevention are applicable and appropriate to projects planned by any minority group. The Statement of Purpose for the Division clearly notes: "The activities of the Division of Prevention are designed to help every American achieve and maintain a level of well-being."

During the period indicated, the Division of Prevention has had numerous contacts with the American Indian and Alaskan Natives. These negotiations have resulted in project activity with both groups.

The Youth Education Branch has recommended two pilot projects targeted toward Indian youth for funding of this Division in FY '75. These programs will explore the effectiveness of a combined recreational and learning experience in fostering the development of responsible attitudes and behavior toward alcohol among Indian youth.

In the Community Prevention Branch, two projects recently were awarded: one, to train Indian personnel in the philosophy and techniques of community education and the development of educational materials; another, to establish a statewide media campaign with the development of media materials for specific populations in Alaska. Other proposals are in various stages of development.

DIVISION OF STATE AND COMMUNITY PROGRAMS

TRAINING

The Training Branch of the Division of State and Community Programs has actively stimulated the development of new training programs to meet the needs of Native Americans. In cooperation with the Division of Special Treatment and Rehabilitation Programs, the Training Branch has developed new programs which are Indian operated and will train Native Americans to deal with their immense alcoholism programs.

A fundamental assumption of the Institute is that Native Americans develop their own resources for training. In this way, programs which are developed will be responsive to the unique needs of the various Indian groups.

The following indicates by fiscal year the number of grants supported and their dollar amounts.

	No.	Amount
FY 1973	4	423,895
FY 1974	3	382,702
FY 1975 Est. Enacted Level	20	2,050,000
FY 1975 Est. Revised Estimate	5	576,509
1976 Estimate	5	618,561

DIVISION OF RESEARCH

Extramural Research

The primary goal of the Institute's Extramural Research Program is to foster the development of effective methods of preventing and treating alcoholism and alcohol abuse. To achieve this objective, the Institute supports a broad program of research on etiology, diagnosis, treatment, and prevention of alcoholism.

Since the establishment of the Institute, research has been supported on various aspects of alcohol abuse and alcoholism among the Indian people. Most of these projects were for the purpose of assessing patterns of drinking, attitudes toward alcohol use, and assessment of special needs for rehabilitation. Two grants were awarded to determine whether genetic inheritance or metabolic differences exist resulting in a greater sensitivity of Indian people to alcohol than occurs among Caucasians. Studies have been conducted among the following: Lumbee (urban and rural); Cherokee; Ojibway (Chippewa; White Mountain Apache; Northern Paiute; Arizona Yavapai; Papago; and unspecified Indians living in a large metropolitan area.

Research among the Indian people has the same problems associated with cross-cultural research, as well as its own unique problems. Uppermost is the acceptance by the people of any researcher, especially if he is Caucasian. All except one principal investigator of the research grants awarded was Caucasian, while the remaining one was Japanese. Most, however, were anthropologists who had previously established rapport with the group under study and, therefore, had access to it. In most projects, the research staff will include an Indian person. Specialized training of Indian researchers would be helpful in alleviating this chronic problem.

One of the NIAAA supported studies, found that Indian drinking differs from drinking in white society. Among some groups, heavy drinking is not condemned nor are there strong sanctions brought to bear on the heavy drinker. The context of the drinking appears to be of overriding importance since heavy drinkers remain sober for long periods of time and tend to drink only in the appropriate drinking context. Many Navajo men, after years of heavy binge drinking, stop drinking entirely and without difficulty in middle age.

A major survey of drinking practices and problems of Urban Indian people in Los Angeles has recently been completed. One major finding confirms the spontaneous cessation of heavy drinking noted in studies of reservation residents. Twenty percent of this sample of heavy drinkers returned to moderate, light drinking or abstained completely without any special treatment or effort.

Another conclusion arising from the findings, was that the problems of urban Indian people are the problems of the urban poor everywhere and cast into the unique patterns of the Indian culture. Indian persons rarely drink alone, but instead prefer a pattern of drinking in the company of friends and relatives with whom mutual sharing can be done. The majority consider alcohol a major problem for Indian people and see only limited resources for helping them to deal with the problem.

Research findings issuing from these grants have been presented at National Scientific Conferences sponsored by professional associations and they have appeared in published form in scientific journals. More research on problems associated with alcohol abuse among the people is essential to determine the scope of the problem, the genesis of alcoholism and alcoholic behavior, and an assessment of needs relating to treatment and rehabilitation.

PROGRAM DEVELOPMENT AND EVALUATION

American Indian Programs served an estimated 30,000 clients and family members in FY '74 at a cost of approximately $12,486,000 to the Federal Government. Those projects reporting to NIAAA received 100% of their revenues from the Federal Government.

The American Indian Program served generally a younger population, including a greater number of females, than other alcoholism treatment programs. The average client age was 37.5 years compared to 41.1 years in the Comprehensive Community programs and 43.7 years in the Public Inebriate Program.

Over 21% of those served were women.

There are fewer married persons in the Indian client group (29.4%), the education mean is lower (grade 10) and the annual income lower than any group other than Public Inebriates ($2,810).

At 180 days after treatment began there were improvements in impairment due to drinking greater than in most other programs and improvement in employment situations, although there remained a high 56% unemployed, down from a high of 78.8% at intake.

Program costs are relatively low and project client loads have increased approximately 30% in persons served each month during the year.

It is apparent that this client group has many problems other than alcoholism to overcome, including high unemployment.

Pilot Monitoring Project: American Indian Projects

Reporting System

In line with the NIAAA policy of obtaining decision-making information on all alcoholism programs funded by the Institute, a pilot monitoring system was begun in six projects in January of 1973. The pilot system has been revised and an additional twelve projects commenced reporting in early August, 1974.

An evaluation report was prepared by Tribal American Consultants to cover the first mine months of information collected. That report has been shared with each of the projects participating.

The system developed by Tribal American, with input from the project staffs involved, obtains both client and management type information. Its key feature is the followup of clients at 30 and 180 days after intake in order to determine their condition change due to treatment.

An internal record keeping system is provided to the projects as a part of the monitoring system. Information from the reporting system is processed monthly and provided back to the projects and to NIAAA in routine monthly output reports. Those reports are being reformated in order to better serve the individual project needs. A seminar was conducted by Tribal American with the original six Project Directors and Data Coordinators as well as those from the other 12 projects in which the system is being implemented for the first time.

Significant Findings, end of F.Y. 74

1. Comprehensive services are being provided by these projects to serve the Indian people. Two projects reported providing detox/emergency care, inpatient, outpatient and residential care. Five of the six reported outpatient care being provided. Two of the projects provided outpatient care exclusively.

2. The target population is being served. It appears that persons are not being reached early enough, however, since the average client has been drinking heavily for over 12 years.

3. In terms of improving client condition, there is an overall positive change in those clients reported on at 180 days after intake into the programs. There was a reduction of 85% in impairment as measured by the impairment index. There was a 64% reduction in alcohol intake. Also, the average days confined the perious month dropped from 3.9 to 1.4 days and days worked increased from 4.1 to 7.2 days.

4. Interactions with other community agencies in terms of client referrals into the project were mostly with other alcohol programs (19.2% for the prior quarter), courts (2.5%), and Tribal Court, etc (10.4%). The major source of contacts is self-referral (42.9%).

5. Average expenditures per person served ranged from $66 to $251 when considered in terms of the total project expenditures. Individual costs per services were quite low with cost of outpatient hours being $2.12 and detox hour $2.91.

Data indicate that this client group suffers from a variety of socio-economic problems.

2/18/75
Prepared by Budget Division
Revised 3/11/75

ESTIMATES OF OE FUNDS THAT BENEFIT INDIANS
OR ARE ATTRACTED BY THE PRESENCE OF INDIANS[1]
(in thousands of dollars)

	1973	1974	1975 Appropriation	1976 Estimate
Office of Education				
Elementary and Secondary Education				
1. Grants for disadvantaged (ESEA I)	$38,967	$42,288	$43,000	$43,000
2. Support and innovation grants:				
(c) Supplementary services (ESEA III)	827	829	737	500[2]
(d) Nutrition and health (ESEA Sec. 808)	211	288	288	288[2]
3. Bilingual education (ESEA VII)	2,601	5,176	5,164	4,450
4. Right to read (Ed. Amends. VII)	14	161	100	---[3]
5. Follow through (Community Services Act, Part B)	3,983	5,053	4,600	3,900
6. Drug Abuse Education (DAE Act)	250	150	---	---[4]
7. Environmental Education (EE Act)	28	25	25	---
Subtotal	$46,811	$53,970	$53,914	$52,138
Indian Education				
1. Payments to Local Educational Agencies for Indian Education (Part A, IEA)	$11,497	$25,000	$25,000	$25,000
2. Special Projects (Parts B and C, IEA)	5,440	15,000	15,000	15,000
3. Program Administration (GEPA)	659	1,265	2,034	2,055
Subtotal	$17,596	$41,265	$42,034[5]	$42,055
School Assistance in Federally Affected Areas				
1. Maintenance and operations (P.L. 874)	$27,669	$30,839	$31,137	$22,680
2. Construction (P.L. 815)	5,528	11,200	10,500	4,725
Subtotal	$33,197	$42,039	$41,637	$27,405

	1973	1974	1975 Appropriation	1976 Estimate
Emergency School Aid				
1. Special projects:				
(a) Bilingual Education project (ESAA, Sec. 708(c))	$304	$627	$ ---	$ ---
(b) Educational television (ESAA, Sec. 713)	---	249	---	---
(c) Special Programs and Projects (ESAA, Sec. 708(a), 708(b)(1))	---	---	356	356
2. State apportionment (ESAA, Sec. 706(a), (b) and Sec. 708(b))	1,182	1,360	---	---
Subtotal	$1,486	$2,236	$ 356	$ 356
Education for the Handicapped				
1. State grant program (EHA-B)	$ 130	$ 240	$1,000	$ 370
2. Deaf-blind centers (EHA-C Sec. 622)	---	77	77	77
3. Specific learning disabilities (EHA-G)	80	65	65	65
4. Regional resource centers (EHA-C)	---	53	53	53
5. Special education and manpower development (EHA-D)	---	200	200	200
Subtotal	$ 210	$ 635	$1,395	$ 765
Occupational, Vocational and Adult Education				
1. Basic vocational education grants (VEA-B)	$3,752	$4,328	$4,328	$4,328
2. Curriculum development (VEA-I)	---	229	---	---
3. Teacher Corps (EPDA, B-1)	4,100	4,100	4,100	2,300
4. Other education professions development (EPDA, Parts C, D,E,F, and Sec. 504)	4,352	4,024	407	---
5. Adult education grants to States (AEA)	1,023	1,070	1,600	1,600
6. Adult education special projects (AEA, Sec. 309)	894	500	---6/	---6/

(continued)

	1973	1974	1975 Appropriation	1976 Estimate
Occupational, Vocational and Adult Education (cont'd)				
7. Adult education teacher training (AEA Sec. 309)	160	160	--6/	--6/
8. Ethnic Heritage Studies (ESEA IX)	---	211	162	---
9. Dropout prevention (ESEA VIII)	421	208	---	--2/
Subtotal	$14,259	$14,621	$10,597	$8,228
Higher Education				
1. Basic opportunity grants (HEA IV-A(1))	$1,105	$2,900	$5,800	$9,000
2. Supplementary educational opportunity grants (HEA IV-A(2))	1,250	1,250	1,250	---
3. Work-study (HEA-C)	1,500	1,500	1,600	1,500
4. Cooperative education (HEA IV-D)	160	115	85	60
5. Subsidized insured loans (HEA IV-B)	3,100	3,200	3,800	4,500
6. Direct loans (HEA IV-E)	1,500	1,600	1,600	---
7. Special programs for the disadvantaged (HEA IV-A(4))	2,933	2,933	2,933	2,933
8. Strengthening developing institutions (HEA III)	3,857	3,517	3,600	3,600
9. University community services	158	150	150	---
Subtotal	$15,563	$17,165	$20,818	$21,593

	1973	1974	1975 Appropriation	1976 Estimate
Library Resources				
1. Grants for public Libraries (LSCA I).....	$242	$250	$250	$135
2. School library resources (ESEA II).....	412	395	558	530 4/
3. Training and demonstration (HEA II-B).....	519	626	505	---
Subtotal	$1,172	$1,271	$1,313	$ 665
Proposed Legislation				
1. Interlibrary cooperation and demonstrations.....	---	---	$500	$500
2. Proposed legislation - Desegregation Assistance Act.....	---	---	500	500
Subtotal	$---	$---	$1,000	$1,000
Total, Office of Education	$130,294	$173,202	$173,064	$154,205

1/ In some instances, the dollars estimated for Indian education constitute the amount of funds "attracted" by the presence of Indians or Indian lands. The two principal programs in which this situation occurs are ESEA I and P.L. 874. For ESEA I, when the local educational agency receives its funds, it determines (within the limits of the law) how the funds are distributed to the individual schools within the district. Thus, the dollars drawn to that district as a result of the presence of Indians do not necessarily benefit those Indians. For P.L. 874, once the Federal funds are at the district level, those funds must benefit all students within that district equally. In this case, only a percentage of the funds drawn to the district as a result of the presence of Indian lands benefit the Indians.

2/ Consolidated under Support and Innovation grants program under Title IV, Part C of Public Law 93-380.

3/ Estimated 1976 figure unavailable because of reauthorization under new legislation, Title VII of Public Law 93-380.

4/ Consolidated under Title IV of the ESEA.

5/ Proposed transfer of $34 thousand for Civilian Pay Raise in FY 1975.

6/ Included under Adult education grants to states.

Elementary and Secondary Education

The overriding objective of the Elementary and Secondary Education Act appropriation is to foster equal educational opportunity through the support of supplementary education services and capacity building activities to increase the ability of State and local education agencies to offer effective and efficient programs. For such purposes, approximately $46,811,000 in ESEA support benefited Indians in fiscal year 1973 and will increase to $52,138,000 in fiscal year 1976.

Pursuant to the legislation, P.L. 93-380, a portion of ESEA Title I funds are transferred directly to the Bureau of Indian Affairs. Such funds are for use in Federal schools either operated by the Bureau or contracted by the Bureau to Indian tribes and financed by the Bureau. Of the approximately 49,500 Indian students in these schools, 32,300 have been identified as Title I assisted students. Additionally, Title I funds reach Indian children enrolled in public schools through the local educational agency. Since fiscal year 1973, and with the exception of fiscal year 1974, Title I allocations for BIA schools have been $17,567,000; the total Title I funding benefiting Indian students ranges from $38,967,000 in fiscal year 1973 to $43,000,000 expected for fiscal year 1976.

The basic strategy of the newly consolidated Educational Innovation and Support grants program, which includes Title III, ESEA, Supplementary educational centers and services and Title VIII, Section 808, Nutrition and Health is to stimulate the dissemination and replication of successful ideas in educational practice. Of the total for the Title III program in fiscal year 1975, approximately $322,601 was transferred to the Bureau of Indian Affairs. Use was made of these monies to support such activities as the establishment and operation of bilingual education programs in early childhood education. Materials and methods relevant to the community are being designed for the purposes of enriching the sensory experiences of Indian children in their preschool years.

Nutrition and health funding is used to support demonstration projects to improve the health and nutrition services available to children from low-income families. In fiscal year 1974, Indian children on the Blackfeet Indian Reservation in Browning, Montana, and Indian children in Rapid City, South Dakota participated in projects funded by this program.

To assist local educational agencies in responding to the special educational needs of children of limited English speaking ability, Title VII of ESEA authorizes the Commissioner to provide financial assistance to encourage the establishment and operation of educational programs using bilingual education practices, techniques, and methods. Bilingual education projects directed toward Indian students were generally integrated into the regular public school curriculum. Activities in Indian bilingual education focused on in-service training of public school teachers to enhance the educational environment of Indian students in a bilingual/bicultural setting and the certification and placement of American Indian teachers in reading and supervisory positions in public schools, thus promoting a system of education of Indians by Indians.

In fiscal year 1974, the total number of Indian participants in Right-to-Read programs was 2,110. Of these, about 70% were under 21 years of age. Using the concepts, data, and strategies of adult basic education programs, Right-to-Read projects conduct reading programs for Indian youth and adults who are functionally illiterate or who have not completed high-school training. In addition to developing the communication skills to enable Indians to function in the dominant economic society and assisting Indian adults to take advantage of occupational and vocational training programs, Right-to-Read projects in Indian communities are directed toward

assisting adult Indian participants to complete and attain the General Education Development Certificate.

Indian children participating in the Hopi Reservation, Arizona, Follow-through project are receiving individualized instruction in language skills, classification and reasoning skills, and perceptual motor development. The program, sponsored by the University of Kansas, is designed for children in grades K-3. The Hopi Reservation project is supported by comprehensive services which include health and dental care, social and psychological services, and nutritional improvement.

Drug Abuse Education Act funds were used for two primary purposes relative to benefiting Indians. Initially, American Indian teams are trained and given technical assistance in two-week live-in programs to prepare them to return to their communities to develop drug abuse prevention programs geared to the specific needs of Indians. Concomitantly, these teams acquire skills needed to catalyze their respective communities in dealing with their particular drug abuse concerns and problems.

Programs conducted under the Environmental Education Act of 1970 demonstrate new approaches in order to assist the development of formal and non-formal environmental education activities at all levels of education. The United Tribes of North Dakota Development Corporation are currently engaged in research activities into Indian materials and sources. To date, this project has developed Indian-oriented environmental education materials for use in the social studies curriculum in grades K-12. These materials, based on Indian traditions and lifestyles, are intended to be supplementary to the standard social studies curriculum.

Indian Education

The Indian Education Act (P.L. 92-318) enacted in June, 1972, concerns the public school education of Indian children at the elementary and secondary levels as well as adult education. Part A of the Act authorizes the Commissioner of Education to award formula grants to eligible local educational agencies and Indian schools located on or near reservations which are not LEA's or have not been LEA's for more than three years to be used to supplement existing elementary and secondary school programs for Indian children. While Part B of the Act focuses on the needs of Indian children, and Part C is directed toward adult Indians, both parts are representative of the intent to provide educational models which will be replicable and integrated with the basic educational curriculum for American Indians.

In fiscal year 1973, Federal support for the Indian Education Act was $18,000,000; fiscal year 1974 funding was $41,759,000; fiscal year 1975 funding is $42,034,300; while the estimate for Federal support in fiscal year 1976 is $42,055,400.

Under Part A formula grants are provided to local educational agencies to benefit Indian children through the support of bicultural/bilingual basic educational services as well as enrichment activities, including the design of culturally relevant curriculum materials, teacher and teacher-aide training, and such supportive services as guidance and counseling. The non-LEA set-aside under Part A, whic will increase from 5% to 10% in fiscal year 1976, primarily supports projects in curriculum development, bilingual education, and cultural awareness.

Part B of the Act is designed to provide financial assistance for planning, pilot, and demonstration projects as well as for basic services to address those needs that are not presently being met by other State and local programs designed to benefit Indian children. Counseling, tutoring, remedial programs, and recreational activities comprise the major components of the Part B strategy. Additionally, efforts under this Part have been undertaken to support the training of teachers, administrators, and ancillary staff; the development of educational programs in "alternative schools," particularly those directed to public school dropouts; and the development of cultural awareness curricula.

Funds appropriated under Part C are directed toward the planning and implementation of adult education projects, primarily focusing on basic literacy and high school equivalency training. Projects undertaken in previous years have typically combined basic education with social support skills, such as literacy through consumer education as well as projects that develop adult Indian educational services in concert with other health, manpower, and social programs.

School Assistance in Federally Affected Areas

In order to provide urgently needed minimum school facilities, Public Law 81-815 authorizes Federal funding for school districts impacted by Federal activities. Eligibility is determined by the number of children who reside with a parent who either lives or works on Federal property. Indian children were the recipients of $33,197,000 under the SAFA program in fiscal year 1973; $42,039,000 in fiscal year 1974; $41,637,000 in fiscal year 1975 and will receive approximately $27,405,000 in fiscal year 1976. During fiscal year 1976, under the Maintenance and Operations segment of this program, it is anticipated that all those Indian children benefiting will be those residing on Indian lands, and thus Part "A" children. Additionally, sections 14(a) and 14(b) of P.L. 815 specifically target construction assistance to school districts serving children living on Indian lands. Thus the appropriations for fiscal years 1973, 1974 and 1975 carried special language that is again requested for fiscal year 1976 specifically earmarking funds for construction that will benefit Indian children. For example, it is expected that the funds requested will provide one new school in New Mexico serving 600 Indian children in 20 classrooms and related school facilities.

Emergency School Aid

Obligations under the Emergency School Aid Act, Sections 708(a), 708(b)(1), and 708(c) as well as the State apportionment funds mandated under ESAA, Section 706(a), (b) and Section 708(b) which benefit Indians are designed both to equalize educational opportunities for those Indians involved and to reduce their isolation from the mainstream culture. However, while no ESAA programs benefit exclusively American Indians, and there are no specific set-asides for this group, it is estimated that in fiscal year 1974 the number of American Indian students enrolled in ESAA-funded school districts was 36,479. Activities conducted under ESAA grants awarded to school districts in heavily populated Indian areas included integrated children's television, bilingual education, evaluation, teacher training and staff recruitment, curriculum revision, and minor classroom remodeling. Community program youth activities aimed at improving the Indian student's self-image through cultural studies programs were also undertaken with ESAA funding.

Education for the Handicapped

Most of the federal aid programs relative to education for the handicapped are authorized by the Education of the Handicapped Act. Programs administered under this appropriation are designed to cohere existing strategies and effect changes in educational patterns in the field by initiating demonstration and model programs and by encouraging innovative techniques and practices. Indians received approximately $210,000 in benefits under the EHA in fiscal year 1973; $635,000 in fiscal year 1974; $1,395,000 during the current fiscal year; while it is expected that $765,000 will benefit Indians in fiscal year 1976.

Under the State grant program, EHA Part B, handicapped Indians in Sandoval County, New Mexico, are being provided with individual programmed instruction through the use of multi-sensory approaches. The purpose of this and similar projects is to raise the level of achievement of these students to a level comparable to the norm. In general, the intent of this part is to assist states in the initiation, expansion, and improvement of programs for the education of handicapped children at the preschool, elementary, and secondary school levels.

The Deaf-blind centers program, authorized under the EHA, Part C, Section G22, supports appropriate educational and diagnostic services for deaf-blind children. In fiscal year 1974, seven of the deaf-blind centers served Indian children, either in residential or day-treatment programs. For example, the Los Lumas Hospital and Training School in New Mexico provides deaf-blind children of the Navajo Nation both full-time educational and specialized intensive professional services to Indian children who have visual and hearing impairments.

The Specific Learning Disabilities program seeks to stimulate the funding of model projects and supportive technical assistance, research, and training activities. The pilot program in Cherokee, North Carolina, directed toward the area's Indian population, has been chosen by the Bureau of Indian Affairs as a model for other BIA schools. Here, Indian children with specific learning disabilities are screened and subsequently provided with diagnostic prescriptive services, while staff development and research activities have also been undertaken with the support of EHA grant money.

Regional Resource Centers have been established to promote the development and application of appraisal and educational programming for handicapped children. At the Southwest Regional Resource Center in Salt Lake City, 58 Indian children are being provided with systematic, comprehensive appraisals which results in their receiving appropriate, quality special education services. Such systematic comprehensive appraisals include: referral and screening, individual assessments, and educational programming.

The Special Education Manpower Development program of the Education for the Handicapped Act provides financial assistance to prepare teachers, supervisors, researchers, and administrators to work either in direct educational service to handicapped children or in preparing other educators who will work with these children. The teacher training project at Window Rock, Arizona, is recruiting approximately thirty third and fourth level students presently enrolled in the Navajo Teacher Education program to complete the requirements for the Bachelor degree in Special Education. Additionally, this project provides in-service training to regular education teachers and administrators to effect attitudinal changes relative to serving handicapped children.

Occupational, Vocational, and Adult Education

In fiscal year 1973, approximately $14,259,000 of the total appropriation for the Bureau of Occupational, Vocational, and Adult Education were estimated to benefit Indians. In fiscal year 1974, this amount increased to $14,567,000, while decreasing to an estimated $10,772,000 and $8,328,000 in fiscal years 1975 and 1976, respectively.

To assist States in maintaining and improving programs in vocational education so that training for career vocations is available to individuals who need such training for gainful employment, Part B of the Vocational Education Act authorizes grants to States based on the formula prescribed in the Act. Of the 9,165,000 students receiving vocational instruction and counseling in fiscal year 1974, approximately 100,650 were Indians, of whom 73.4% were high school students, 10.5% were postsecondary students and 16.1% were adults.

Part I of the Vocational Eudcation Act authorizes grants and contracts with colleges and universities, State boards, and other public or nonprofit private agencies for the development, testing, and dissemination of vocational education curriculum materials for use in teaching occupational subjects. In fiscal year 1974, the Far West Laboratory for Educational Research and Development conducted such a project whose goal was the design, development, and testing of a program of study for American Indian youth in grades 7-9 that will integrate the traditional curriculum with career awareness, exploration, and orientation. Native American students were to be introduced to a broad spectrum of occupational opportunities, helping them to develop (1) increased self-awareness; (2) an awareness of career options; and (3) the knowledge to make rational choices among careers based on individual interest.

Part B of the Education Professions Development Act is intended to strengthen educational opportunities for children of low income families and to improve the quality of programs of teacher education. In those projects affecting Indians, Indian paraprofessionals, pre-service and inservice trainees and graduates are trained to teach in Indian schools and subsequently serve as success models for the Indian population. In addition, the personal development of ancillary educational professionals is furthered through funding under Parts C, D, E, F, and Section 504 of the EPDA. The principle of such programs as career opportunities, training of teachers for Indian children, new careers, and urban/rural school development is to create alternative and expanded career patterns in education. Such projects are demonstrating a variety of techniques which benefit Indian children.

For example:

--In Seattle, Washington, teachers for Indian children are trained using a competency-based training approach where each participant acquires competencies at his own rate and is evaluated on his performance.

--At an urban/rural project in Bayfield, Wisconsin, where 1/3 of the participants are Indian, intensive retraining for the entire faculty of the participating school is provided. The content of the program is determined in conjunction with the local community council of parents and citizens and is geared toward increasing overall pupil achievement.

--A New Careers in Education project located in Oklahoma is focusing on informing and recruiting potential Native American students to be Industrial Arts, Trade, and Technical Education teachers.

--Arizona State University's career opportunities program enrolls 52 participants from five of the State's Indian reservations. Through attendance at college course work on an extension basis during the academic year and on-campus enrollment during the summer, these participants are trained to teach upon their subsequent return to their communities.

The Adult Education Program authorized by the Adult Education Act of 1966, as amended, is designed to serve under-educated adults, primarily those with less than an 8th grade education. The program's primary objective is to support programs which teach communication, computation, and social living skills to educationally disadvantaged adults to enable them to become employable, productive, and responsible citizens.

Through adult education grants to States, to be matched by State and local funds, opportunities are provided in local communities for adults to improve their skills in speaking, reading, and writing so that they can improve their ability to benefit from occupational training. No Indian projects as such exist under this program. However, special attention is given to the needs of persons of limited English-speaking ability. For example, over 400 Crow Indians in Montana are the recipients of comprehensive adult education programs as well as of mini-course offerings in consumer education, Crow culture, literacy in English and Crow and various civic, financial, and home-related subjects. This particular continuing Adult Basic and Secondary Education program is also establishing linkages with the six-reservation Idaho Staff Development project and with the Northern Cheyenne tribe.

Consistent with the principle of reaching educationally disadvantaged adults, adult education special projects funds are used to initiate experimental methods, techniques, and materials for the adult undereducated. In fiscal year 1974, forty-seven special demonstration projects were funded of which four dealt with the subject of Indian education. Complementing the objective of enabling adults to become competent and self-reliant individuals, funds are authorized for regional and non-regional teacher training programs. In fiscal year 1974, projects in Indian education leadership development were supported for the purpose of training Indian teachers, administrators, counselors, and paraprofessionals to assume full-time careers in adult education.

Ethnic heritage studies were mandated by the Congress in the Education Amendments of 1972 to increase the understanding and appreciation of the nation's multi-ethnic society and to encourage citizens to participate more harmoniously in their communities. For example, an ethnic heritage studies program in South Dakota which involves twelve schools in the State is developing curricular materials focusing on the culture of the South Dakota Sioux and other Plains Indians. Under this grant award, a series of teacher workshops in Native American heritage will be held in the spring of 1975.

Title VIII of the Elementary and Secondary Education Act of 1965 authorizes the granting of awards for dropout prevention programs which develop and demonstrate educational practices of promise in reducing the number of children who fail to complete school through the twelfth grade. One such program benefiting Indians, located in Riverton, Wyoming, is a multi-ethnic joint venture involving the community in cultural and career development activities. Primarily through the use of preventive and in-and-out-of school projects, potential and actual dropouts are identified and treated.

Higher Education

The Bureau of Postsecondary Education administers a variety of assistance programs in which Indians are eligible to participate, although none of these programs is specifically designed to assist Indian students. The Bureau's program dollars benefiting American Indians increased from $15,563,000 in fiscal year 1973 to an estimated $21,593,000 in fiscal year 1976.

While American Indians are known to be eligible and active participants in the Basic Educational Opportunity Grants program, which provided financial assistance according to a uniform scale to assist eligible persons to finance their postsecondary education, data on participation by race is not yet available. Thus, estimates are based on the proportion of Indian students to the entire student population engaging in undergraduate work at colleges, vocational, technical, and proprietary schools. Additionally, Indians were recipients of grant awards under the Supplemental Educational Opportunity Grant program which is intended to enable those postsecondary students of exceptional financial need to continue their education.

The main object of the College Work-Study Program is to promote the part-time employment of postsecondary students who must earn a part of their educational expenses. Needy Indian students who attended participating higher education institutions were paid wages for work arranged by the institution, either on-campus or off-campus with a nonprofit public service agency.

Title IV-D of the Higher Education Act supports grants to help higher education institutions plan, establish, expand or carry out cooperative education programs. Among those colleges receiving grants was the Navajo Community College, Arizona, for administration of a cooperative education program. This College also acted as the fiscal agent for a six-college consortium (all American Indian institutions) to train cooperative education personnel.

The guaranteed student loan program, Title IV-B of the Higher Education Act of 1965, as amended, authorizes a program of guaranteed and subsidized loans to help students finance educational costs at eligible postsecondary institutions. Approximately 9,300 Indian students whose adjusted family income was less than $15,000 were eligible for such loans totalling up to $2,000 for the 1973-74 academic year.

In fiscal year 1975 an estimated 2,400 needy Indians received long-term, low-interest loans under the direct loan program to enable them to pursue their courses of study at institutes of higher learning.

Special programs for the disadvantaged is comprised of the following four components: talent search, designed to encourage qualified youth to enter postsecondary educational programs; upward bound, providing skills and motivation for success in education beyond high school; special services for disadvantaged students, providing remedial and other special services; and educational opportunity centers, assisting residents of low-income target areas in applying to and securing financial aid from institutions of postsecondary education. In fiscal year 1975, about 14,600 Indian students benefited from these programs, receiving average benefits of $272 in special services, $69 in talent search, and $879 in upward bound. Under the talent search program, Indian students who had dropped out of either high school or college were counseled about postsecondary educational opportunities and financial aid in an attempt to encourage these youth to reenter educational programs. Indians identified as having need of specific kinds of support to remain in postsecondary educational study were offered tutoring, counseling, and remedial work in special services for disadvantaged students projects. Upward bound projects directed toward American Indian populations focused on the development of skills for postsecondary education through residential summer programs in conjunction with academic year follow-up activities for those under-achievers who were considered to have potential for postsecondary education. Those Educational Opportunity Centers designed especially for Indian populations served largely as clearinghouses for information

concerning financial aid and academic support as well as providing counseling and tutorial services.

The strengthening developing institutions program provides grants on a competitive basis to developing colleges to assist them in strengthening their academic, administrative, and student services programs so that they may participate adequately in the higher education community. While the law does not specify set-asides for Indian institutions, these groups have been grant award recipients over the past several years. Under this program, the American Indian Higher Education Consortium was established in fiscal year 1974 and has since engaged in the development of Indian-oriented curricular materials, the initiation of a data base and research capability for satellite colleges; the review of accreditation relative to the education of Indian students; human resources planning; and the review of institutional development at member colleges.

The University Community Services program provides allotments to States to help solve community problems through cooperation with postsecondary institutions. In Indian communities, funding under the University Community Services program was used to support the improvement of tribal leadership, especially in policy-making. Specifically, the project was intended to increase skills in dealing with the rights and responsibilities of individual tribal members, the judicial system, and tribal law in relation to Federal law.

Library Resources

The Federal role in libraries has recently shifted toward encouraging demonstrations of effective library practices and supporting cooperative library services patterns at the local, State, and regional levels.

In fiscal years 1973 and 1974, under the Grants to Public Libraries program, nearly 300,000 American Indians in sixteen States received new or improved library services. Almost the same number of Indians will be served in fiscal year 1975 with approximately $250,000 in federal support under LSCA, Title I. Services are provided both on and off the reservation and include outreach programs as well as a materials collection of Indian culture, bookmobile services and special library services to the blind and physically handicapped. For example, during the current year the Hopi Reservation in Arizona, working with five community libraries, developed and conducted a weekly arts and crafts program for the general public. In fiscal year 1976, the funds available from LSCA I for American Indians will be approximately $135,000. Similar services will be accomplished.

Nearly 225,000 American Indian elementary and secondary school children benefited from School Library funding. Services were provided through both the Bureau of Indian Affairs and the State Educational Agencies and were provided on the reservations as well as in other public schools. In fiscal year 1975 this program and NDEA III will provide Indian children with laboratory and special equipment and materials for elementary and secondary schoool instruction in science, mathematics, and modern foreign languages. It is anticipated that in fiscal year 1976 these programs consolidated under ESEA IV-B will provide approximately $530,000 to American Indian children in programs and services reflective of past efforts.

During fiscal year 1974, sixty American Indians participated in Library training programs specifically designed to recruit them into the profession to serve the informational needs of Indians. Of these sixty, fifteen will be receiving A.B. degrees in Library Science, and forty-five will receive training at the paraprofessional level. In addition, approximately two American Indians will be recruited for participation in the fellowship program.

In the Demonstration program in fiscal year 1974, two projects were specifically designed to serve Indians on reservations. It is estimated that 19,000 Indians on four reservations will be served by these projects. Recipient tribes will be: Arapahao, Shoshone, Navajo, Sioux, and Mohawk. With a reduction from the fiscal year 1974 appropriation, approximately $205,000 will be available in the Library Career Training Program for training American Indians in Library careers and approximately $300,000 will fund demonstration projects which will benefit Indians in fiscal year 1975.

Proposed Legislation

Two new legislative thrusts are being considered by the Office of Education: the Interlibrary Cooperation and Demonstration Act and the Desegregation Assistance Act. Under the proposed Library Partnership Act, grants and contracts would be awarded to public non-profit agencies and institutions primarily, to ensure the equalization of public access to libraries and library services. These awards will be used to support innovation activities and initiate comprehensive national demonstration projects of improved methods of service networks for the sharing of information. It is anticipated that $500,000 of the authorized funding for this legislation will benefit Indians in fiscal years 1975 and 1976.

The Desegregation Assistance Act would replace the Emergency School Aid Act which assists school districts which are implementing desegregation plans. The proposed DAA would only provide financial assistance to those school districts implementing desegregation plans for the first time.

NATIONAL INSTITUTE OF EDUCATION
AMERICAN INDIAN PROJECTS

	FY1974 Actual	FY1975 Estimate	FY1976 Estimate
		($ in thousands)	
TOTAL FUNDS OBLIGATED	$992	$770	$831

The projects that focus on American Indians represent a specific part the National Institute of Education's more general equal educational opportunity mandate. Program objectives include:

- o increasing the reading, spoken and written English language skills of Indian children.
- o making effective improvement in the rural learning of Indian people.
- o investigating the vocabulary development of Menominee Indians.
- o assessing the educational needs of Navajo people.
- o creating tests for diagnosing reading difficulties of Indian children.

SOCIAL AND REHABILITATION SERVICE

Estimated Cost Data for Programs Serving American Indians

(Dollars in Thousands)

Appropriation/Program	1974	1975	1976
Public Assistance:			
Maintenance assistance	$58,000	$53,000	$57,000
Medical assistance	6,000	7,000	8,000
Social services	17,000	20,000	21,000
Research	1,000	3,000	8,000
Total	82,000	83,000	94,000

The maintenance assistance and social services estimates are projections. American Indians are a basic classification identified by percent of recipients by category in the Recipient Characteristics Studies published by the National Center for Social Statistics. These data were used to determine percentages for 1974, 1975 and 1976. The resulting percentages were then applied against the total Federal program costs in each of the three years.

There are approximately 31,000 Indians currently receiving medical assistance through the Medicaid program. Because the Indian population is relatively young, we do not expect that as large a proportion of their medical care represents high-cost institutional care.

Based on the data shown above and the trends in the Medicaid program, the Federal costs for the American Indians are estimated at $6, $7 and $8 million for 1974, 1975 and 1976 respectively.

Public assistance research funds nine (9) projects where American Indians are the major focal group. Two of these projects focus primarily on American Indian youth. One project is testing the effect of disregarding certain Indian income in determining eligibility for welfare payments to determine whether the increased income will be used in improving their life style and socio-economic outlook. Another project is testing the effect of delivering health services in a remote rural area and providing indigenous staff with paramedical training so that they may better provide for the health care needs of their own people. The other projects involve the delivery of social services. Two projects, one in New Mexico and one in Arizona will provide social services to eligible recipients on the Navajo Reservation.

Amount Benefiting Indians

	FY 1973 Actual	FY 1974 Actual	FY 1975 Revised	FY 1976 Estimate
Office of the Assistant Secretary for Human Development	$15,967,000	$47,989,000	$50,439,000	$51,080,000
Office of Child Development	$10,960,000	$11,349,000	$12,500,000	$13,000,000

The Office of Child Development funds Head Start programs to provide comprehensive developmental services to pre-school Indian children and their families. Grants are made directly to individual tribes and tribal groups on reservations. Additional Indian children are served in urban areas where there are Head Start grantees where they have relocated with their families; however, estimates are not available of the amount of Head Start funds benefiting urban Indian children. The Office of Child Development also funds demonstrations of child abuse prevention and treatment approaches which are designed to meet the needs of reservation and urban Indian families. In addition, several other research and demonstration projects have been funded to analyze and demonstrate ways to improve child welfare services to Indian children.

Office of Youth Development	$173,000	$200,000	$109,000	$ -0-

The Office of Youth Development funded youth service systems on four Indian reservations and in one city with a concentration of Indian youth. These projects assisted Indian communities to coordinate resources available for the prevention, treatment, and control of juvenile delinquency. The Youth Service System Program is being phased out in FY 1975 since the authorization in Title IV of the Juvenile Delinquency Prevention Act expires June 30, 1975. In FY 1975 and FY 1976, a new runaway program will be funded by the Office of Youth Development. Estimates are not yet available of the number of Indians to be served by the runaway shelters.

Rehabilitation Services Administration	$3,534,000	$3,900,000	$4,080,000	$4,080,000

The prime purpose of the State-Federal vocational rehabilitation program is to provide such services to physically and/or mentally disabled persons as required to render them ready for and placement into gainful occupation. Information regarding rehabilitation services according to race, including Indians, is collected on the Case Service Report. Form RSA-300. The Indians rehabilitated under the vocational rehabilitation program accounted for six-tenths of one percent of total rehabilitations in Fiscal Years 1973 and 1974. This percentage relative to Indians is used to estimate the dollars amounts.

Administration on Aging	$1,300,000	$1,640,000	$1,750,000	$2,000,000

These funds represent the amount that States have earmarked under Titles III and VII of the Older Americans Act for serving older Indians. A few reservations are designated as Planning and Service Areas with established Area Agencies on Aging. Most older Indians however reside in Planning and Service Areas that are not comprised exclusively of Indians. In the latter situation, some State and area agencies have earmarked funds for the development of a specific project to serve Indians, such as nutrition or transportation. In some instances States utilize the funds to better assess the needs of older Indians or to develop better techniques of service delivery to older Indians.

Office of Native American Programs	1/	$30,900,000 2/	$32,000,000 2/	$32,000,000 2/

The Native American Program, NAP, develops innovative approaches for dealing with the special needs of American Indians, Native Hawaiians, and Alaskan Natives and provides technical and financial assistance to enable them to move toward economic self-sufficiency. The purposes of NAP include: (1) strengthening of tribal governments to enable them to effectively manage and utilize available resources; (2) support of a range of services to meet individual and family needs; (3) support for establishment and operation of urban centers serving Indian people living off reservations; and (4) funding to encourage self-help and community economic development efforts.

Direct-funded grantees provide services which are available to over one-half of the approximately one million eligible Native Americans in the United States. The grant program in 36 states includes 273 tribes, groups and Alaskan villages, as well as 58 urban organizations.

1/ Program in the Office of Economic Opportunity

2/ Includes other native Americans in addition to Indians.

CEREBRAL PALSY

Cerebral palsy is a common handicapping condition, not due to progressive disease, and characterized primarily by spastic paralysis or impairment of control or coordination over voluntary muscles. Manifestations may change over the lifespan of the individual. It is often accompanied by mental retardation, seizures, and disorders of vision and communication.

Cerebral palsy may be either congenital or acquired, but it is always the result of damage to the brain's motor control centers. It has many known or suspected causes, and there is no single effective preventive measure. Although a cure is not available for the condition, the afflicted person can be helped to minimize the effects of cerebral palsy and to compensate for developmental delays.

According to the United Cerebral Palsy Associations, Inc., a national voluntary health agency, three-quarters of a million persons in this country have cerebral palsy. About 15,000 babies are born with cerebral palsy each year, or one newborn in every 200 live births.

The Department's research activities in cerebral palsy are centered in the National Institutes of Neurological Diseases and Stroke (NINDS) of the National Institutes of Health; its rehabilitation activities are the responsibility of the Rehabilitation Services Administration of the Office of Human Development.

Obligations for Programs in Cerebral Palsy

	1972	1973	1974	1975 estimate	1976 estimate
National Institutes of Health:					
National Institute of Neurological Diseases and Stroke.....	$13,992,000	$14,944,000	$12,890,000	$12,246,000	$13,197,000
Office of Human Development:					
Rehabilitation Services Administration:					
Basic State Grants.....	2,800,000	2,945,000	4,550,000	5,440,000	6,120,000
Total.....	16,792,000	17,889,000	17,440,000	17,686,000	19,317,000

2

NATIONAL INSTITUTES OF HEALTH

National Institute of Neurological Diseases and Stroke

The term cerebral palsy covers a group of diverse syndromes affecting the brain which are manifested by impairment in motor function. These are the result of many causes, most of which presumably occurred during pregnancy, labor, delivery or early in life.

Kinds of Cerebral Palsy

The various syndromes known as cerebral palsy are classified according to several predominant clinical manifestations. Spastic Cerebral Palsy is characterized by increased muscle tension and exaggerated reflex activity in an arm and a leg on the same side (hemiplegia) or arms and legs on both sides (tetraplegia or quadriplegia). In some cases, the lower limbs may be more involved than the upper limbs (diplegia) or both legs may be involved with complete sparing of the arms (paraplegia). In rare cases, only one limb (monoplegia) or three limbs (triplegia) are involved. Dyskinetic Cerebral Palsy is characterized by uncontrolled and purposeless movements which disappear during sleep. The most common types is athetosis involving usually all four extremities, but also the face, neck, and, to a lesser degree, the trunk. Ataxic Cerebral Palsy is characterized by an inability to coordinate voluntary muscular movements.

The manifestations of more than one type of cerebral palsy may occur in some children. Also children with cerebral palsy may have associated defects which in some instances may be more disabling than the motor disability itself. The most common of these are seizure disorders and mental retardation. Cerebral palsy is often accompanied by speech disorders, including different degrees and expressions of aphasia (total or partial loss of the power to use or understand words) and articulatory disturbances. Faulty hearing, visual defects, perceptual and conceptual difficulties, and personality disorders are other problems sometimes associated with cerebral palsy.

Management of Cerebral Palsy Patients

Because cerebral palsy is such a complex condition, it can be most effectively managed through the team approach. Management varies with the child's age, the type and severity of involvement, the presence or absence of seizures, and the level of intellectual capability. All of these factors require skillful management by a team of physicians, therapists, social workers, educators, and psychologists. Recent focus on the whole child and his family, including social and educational factors, has helped family adjustment and the child's education and future occupation.

Just as no single professional can provide all that is needed for children with cerebral palsy, no one element of Government can respond to such a mandate. Consequently, responsibilities for research and service to children with cerebral palsy cross both departmental and agency lines and require cooperation and coordination at many levels.

Treatment of Cerebral Palsy

Spasticity is the dominant motor handicap in most cases of cerebral palsy. It can be treated symptomatically by physical and occupational therapy, and with orthopedic and neurological techniques. The potential of certain medications for treatment is under study.

In order to determine the correct therapeutic approach, it is necessary to observe carefully what the patient can do and evaluate the degree of spasticity. In a rehabilitation research study supported by the Social and Rehabilitation Service at the Tel Aviv University Medical School, Zrifin, Israel, Dr. Ralph Spira is testing a method for more accurately estimating the degree of spasticity. The researcher suggests that this method might also help evaluate the responses to therapeutic and rehabilitative measures given to the 21 adolescents with cerebral palsy in the study.

Drugs such as L-Dopa, used for many years for the treatment of Parkinson's disease, and sodium dantrolene are being evaluated to determine whether or not they might be effective in controlling muscle tension. The use of surgery, pneumatic braces, and injections of alcohol are continuing to be appraised.

Experimental methods of treatment have met with limited initial success. Dr. Irving S. Cooper, St. Barnabas Hospital for Chronic Disease, Bronx, New York, has developed an electronic brain pacemaker which in several cases has reportedly helped to control spasticity and tremors. The use of biofeedback--training patients to control their involuntary body functions consciously--is a second new approach to the handling of cerebral palsy. This technique is being assessed by NINDS grantees at Children's Medical Center in Boston, Massachusetts. They hope to develop effective procedures for self-control of muscle activity in normal persons and to test them in reducing uncontrolled and purposeless movements in appropriate patient groups. Dr. William W. Finley, research psychologist at Children's Medical Center in Tulsa, Oklahoma, reports that he was able to reduce tension in four patients with athetoid cerebral palsy in six weeks of biofeedback training.

Treating the Disability

The psycho-social consequences of a disability can sometimes be more handicapping than the disorder itself, resulting in progressive social deprivation and isolation. The level of functioning for a child with cerebral palsy depends in part upon the family's ability to accept and understand him and his handicaps realistically and to encourage him to function as normally as possible.

In a study supported by the NINDS and the National Institute of Mental Health, Alcohol, Drug Abuse, and Mental Health Administration, Dr. Kate L. Kogan, University of Washington, Seattle, is investigating the interpersonal aspect of child cerebral palsy to learn more about how the child relates to his family and his therapists. A recently published report of her work suggests that the treatment system, perhaps through a multidisciplinary approach, needs to actively encourage attention to positive and total assets as well as to the specific abnormalities toward which therapy is directed, and thus to increase the positive reinforcements and rewards available to the family.

Collaborative Perinatal Study

Much of the NINDS research on cerebral palsy is centered in the Institute's Collaborative Perinatal Study, a prospective, multidisciplinary, long-term investigation of children of 55,000 pregnancies from birth through early childhood. Since 1959, scientists in 12 participating hospitals have been observing these children, and recording data about them to determine if it is possible to discover the causes of cerebral palsy and related disorders and to prevent them.

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In the past year, considerable headway has been made in evaluating these data. Consistent definitions and criteria have been established. Records of all children with definite or suspect diagnosis at seven years have been reviewed and reclassified. Interval histories have been examined to separate "acquired" from "congenital" cerebral palsy.

There are more than 200 cases of cerebral palsy in the study group, or about one in 200 births. This figure may include some milder cases than are usually reported, but provides a fuller spectrum of motor defects than has heretofore been available. The data also indicate that many children with definite cerebral palsy diagnosis at one year, do not show such deficits at seven years but do remain at high risk for mental retardation.

The data further suggest the possibility of isolating variables which permit prediction. For example, among children with cerebral palsy who could pull themselves to a standing position at one year of age, few showed significant lack of muscular control or coordination at age seven.

Analysis of data on suspected causes of brain damage which can culminate in cerebral palsy is also proceeding. The study of perinatal deaths and congenital malformations, for example, is designed to determine maternal drug utilization patterns during pregnancy and provide for a rapid evaluation of drug teratogenicity (malformation producing capability) through the use of a screening device. A project on neonatal hyperbilirubinemia (jaundice) has as its goal the assessment of the relationship of intermediate levels of serum bilirubin on subsequent neurological and mental development of children. Also under continuous investigation are the influence of genetic and socioeconomic factors, toxemia, maternal infection during pregnancy, and maternal anesthesia and analgesia during labor and delivery, on the neurologic development of children.

Importance of the Collaborative Perinatal Study

Rubella is a known cause of birth defects, including cerebral palsy. Prior to the rubella epidemic in 1964, rubella defects were thought to be associated with disease only in the first trimester of pregnancy. The Study contributed to the knowledge of the capacity of the rubella (German measles) virus to cause damage to the unborn baby at any time during pregnancy. This discovery lent impetus to the campaign to develop a rubella vaccine. Since the introduction of this vaccine, more than 40 million doses have been given. The continuing decline in the annual number of reported cases of acquired and congenital rubella which has resulted from the use of this vaccine is even more meaningful in view of the fact that a nationwide rubella epidemic predicted for early 1970 did not occur.

Evidence from the Study indicating that limiting maternal weight gain during pregnancy may adversely affect the child has contributed to a re-evaluation of this practice. The Study will also establish more precisely the relationship between asphyxia at the time of birth and cerebral palsy.

Other Cerebral Palsy Research

NINDS scientists at NIH and Institute grantees at medical centers throughout the country are also studying cerebral palsy and birth injuries resulting in brain damage. Dr. Charles F. Barlow at Children's Hospital Center in Boston, Massachusetts, and Dr. Guy M. McKhann, The Johns Hopkins University, both have long-range NINDS grants to improve understanding of normal development and the response of the developing and mature nervous system to injury.

Premature babies are especially susceptible to severe jaundice, a well documented cause of cerebral palsy and other birth defects. Jaundice occurs when an excess of yellow pigment called bilirubin builds up in the blood and is deposited in tissues.

Until the late 1950's, complete replacement of the baby's blood was the only method to treat jaundice. Since then, both sunlight and artificial light (phototherapy) have been used in treatment of mild cases of jaundice. Although 95 percent of the hospitals that deliver at least 1,000 babies annually use phototherapy to treat jaundiced newborns, there is as yet no standardized way to use it. A scientist at Downstate Medical Center, Brooklyn, New York, Dr. Audrey K. Brown, is now attempting to establish guidelines. The results of her study, which is supported by the National Institute of Child Health and Human Development and the Food and Drug Administration, should determine definitely whether phototherapy can significantly reduce brain damage to newborns who develop significant jaundice and whether it can prevent jaundice in immature babies.

Dr. Richard Wennberg of the University of Washington, Seattle, a grantee of the United Cerebral Research and Education Foundation, is also concerned with the problem of jaundice. He is attempting to develop more accurate methods of measuring bilirubin in the blood.

Fundamental neuropathological studies of jaundice are being conducted by Dr. Robert Katzman and his group at an NINDS-supported Neurological Clinical Research Center at Yeshiva University.

Asphyxia during pregnancy is another cause of brain damage which may result in cerebral palsy or mental retardation. The term asphyxia describes any state whereby the fetus sustains an impairment in its respiratory gas exchange with the mother. However, the severity of asphyxia required to produce injury, the basis for the wide diversity of patterns of injury induced, and the clinical circumstances which give rise to asphyxia have remained poorly defined. Particularly unclear have been the physiologic alterations which underlie the many pathologic changes collectively termed perinatal brain damage.

Working with non-human primates, Dr. Ronald E. Myers, NINDS, has recently attempted to provide an experimentally-based classification of the asphyxias and to describe the types of brain injury they produce. This classification should make it possible for scientists to report their findings more precisely and to correlate patterns of injury caused by the asphyxias in the animal fetus with certain kinds of brain damage in human infants.

In another study of the effects of perinatal asphyxia in monkey fetuses, Dr. Myers, in collaboration with Institute grantees, is attempting to reproduce the nerve damage of human cerebral palsy and mental retardation. This goal has been partially achieved, and the investigators are continuing their efforts to determine the critical parameters which lead to the pattern of brain injury produced. The researchers are also trying to develop techniques to prevent the deterioration of the fetus when asphyxiated and to prevent or postpone the occurrence of perinatal brain injury.

Hypoxia means that the oxygen pressure is below normal. Dr. Paola S. Timiras, an NINDS grantee at the University of California, Berkeley, has conducted animal studies at the University's White Mountain Research Station on the effects of natural hypoxia (high altitude) on the fetal central nervous system.

Evidence from this research indicates that fetal brain maturation is delayed at high altitudes and that the effects of high altitude depend on the duration of the exposure and the age of the fetus. These findings suggest, contrary to previous beliefs, that the high altitude environment is not entirely harmless during prenatal life.

Lack of oxygen sometimes occurs in the fetus during labor, and results in brain damage to the infant. A grantee of the United Cerebral Research and Education Foundation, Dr. J. W. Goodwin, Women's College Hospital, Toronto, is assessing changes in the fetal circulatory system with the hope that a practical method can be found for measuring blood pressure in the arteries carrying oxygen to the brain.

The relationship between infections in the perinatal period and birth defects such as cerebral palsy is being widely studied.

In an investigation of the safety of administering rubella vaccines during pregnancy, Dr. John Sever, NINDS, demonstrated that only rarely is there transmission of the vaccine virus to the placenta or the fetus. This suggests the possible more general use of these vaccines during pregnancy.

Mumps occur less frequently than German measles during pregnancy and, in the majority of cases, does not cause fetal damage. However, infection during the first trimester has occasionally been associated with spontaneous abortion and several congenital defects. This association has led to concern that live mumps vaccine administered to a pregnant woman might pass through the placenta to the fetus and possibly cause damage. Recent findings by Dr. Terry Yamauchi, University of California, Los Angeles, suggest that these vaccines may possibly pose a threat to unborn infants and should be used with caution in women of childbearing age. This research was supported in part by the National Institute of Allergy and Infectious Diseases.

The role of the body's natural immunity in repelling viral infection is another area of special interest to NINDS scientists. Studying the immune response in fetal monkeys, Dr. Ronald E. Myers has demonstrated that early in gestation these animals are unable to produce significant amounts of interferon (an infection inhibitor). Later in gestation, however, their ability to produce interferon is similar to that of adult animals. This suggests that the interferon mechanism of protection is unavailable to the early fetus, thus putting it at risk beyond that of older fetuses and adults.

Cytomegalovirus is another important cause of viral-induced birth defects. Unlike congenital rubella, which occurs in epidemics, human cytomegalovirus is present in a community at all times but only in small numbers of cases. It is estimated that one percent of all babies born in this country are congenitally infected with cytomegalovirus. Although only a small percentage (an estimated 3,100) of these suffer severe damage, the cumulative annual toll taken by cytomegalovirus exceeds that attributable to rubella in the pre-vaccine days.

Dr. Thomas Weller of Harvard University, who received the Nobel Prize in 1953 in medicine for his work on the polio vaccine, is among the outstanding researchers studying cytomegalovirus as a cause of cerebral palsy and brain damage. Dr. Weller's project is partially funded by the United Cerebral Palsy Research and Education Foundation.

The detection of high-risk infants with cytomegalovirus and other infections is hampered by the lack of specific tests to identity these children. Dr. Sheldon Korones, an NINDS grantee at the University of Tennessee, Memphis, is attempting to develop simple specific tests for cytomegalovirus and other infections, so that appropriate treatment can be used.

The most practical method for prevention of cytomegalovirus-induced congenital defects would be vaccination of women well in advance of conception. Dr. S. D. Elek of St. George's Medical School, London, has recently developed an experimental vaccine that attempts to give protection through an under-the-skin inoculation of a strain of cytomegalovirus adapted in tissue culture. Although preliminary tests of this vaccine were successful in stimulating antibody production without causing important immediate side effects, these studies are still in the preliminary stages. Today, the rubella vaccine is still the only vaccine against a human teratogenic (malformation producing) virus presently licensed for use.

Drugs taken by a woman during pregnancy are also known or suspected causes of brain damage. In one study, Dr. E. B. Hook, Albany Medical College, New York, is investigating an association of female sex hormone injection of the mother with adverse fetal outcome. This is part of a complete analysis of the effects of maternal drug intake upon pregnancy in the Collaborative Perinatal Study.

Evaluation of Research Progress

Although much is yet unknown about the causes and management of cerebral palsy, research progress has been steady and occasionally dramatic. Scientists believe that many birth defects could be prevented by a wider application of this new knowledge. One simple step would be for all women of childbearing age--and even young girls--to receive anti-rubella vaccine. A second step would be for all couples to have their blood analyzed for Rh factor incompatability (a destructive blood disease), and for an Rh-negative mother to be given an Rh vaccine after delivery which will protect future children against Rh-incompatability. Researchers also point out that genetic services now are available in many cities. Some of the centers provide genetic counseling, and others provide prenatal diagnosis of hereditary defects. Good prenatal care is the best protection against non-genetic birth defects, and research findings strongly suggest that the mother-to-be avoid the use of unprescribed drugs and medicines, and follow her physician's instructions regarding those prescribed. Research also indicates that the pregnant woman should avoid persons with infectious diseases and give particular attention to proper nutrition.

Research has made all of these preventive measures available. As more and more people are made aware of them and their use becomes more widespread, it is anticipated that brain damage which results in cerebral palsy can be significantly reduced. Goals originally set by the Collaborative Perinatal Study are gradually being realized. Because the follow-up of children to age seven-to-eight years has just recently been completed, much data are still to be analyzed and interpreted. Some of these data are unique in their quality and completeness, their prospective nature, and in the safeguards which were imposed to assure comparability in their collection. Already they are being utilized by scientists. In their totality, these data will constitute a national research resource for many years to come.

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OFFICE OF HUMAN DEVELOPMENT

Rehabilitation Services Administration

The Rehabilitation Act of 1973 mandates that the vocational rehabilitation program give priority in the provision of services to people who have the most severe physical or mental handicaps. Rehabilitation of the individual with cerebral palsy will be a priority activity, not only because of the severity of the disability itself, but also because of the broad range of handicapping conditions it presents. In virtually every case, a multidisciplinary approach is essential to the development of an appropriate rehabilitation plan for individuals with cerebral palsy. In an effort to expand and intensify rehabilitation services for this disability category, the Rehabilitation Services Administration has utilized several of its grant programs, and some examples of these grant activities are cited below.

A project was supported to operate a special rehabilitation program for severely disabled college students, including those with cerebral palsy, attending the University of California at Berkeley. The grant assisted with the costs of living in a residential unit staffed with professionals to provide the services necessary to maintain the students' health at an optimum level while they were in college. This project was so successful in meeting the needs of these severely disabled students that its activity has now been taken over by the California Department of Rehabilitation as part of its operating program.

In addition to 3 Rehabilitation Research and Training Centers in Mental Retardation (University of Wisconsin RT Center, University of Oregon RT Center, and the Texas Tech RT Center), six Medical Rehabilitation Research and Training Centers are engaged in studies on cerebral palsy. These research projects deal with the measurement of life success in terms of survival, and educational, vocational and marital achievement in CP, self-care in CP, muscle spasticity in CP, and the medical and allied health services needed by the Developmentally Disabled, including the cerebral palsied. In addition, the George Washington University RT Center has involved clients with severe disability due to cerebral palsy in research projects dealing with the development of modern vocational objectives for the severely disabled homebound.

Neurological research is considered a priority area for RSA support. Neurological research is considered to cover central nervous system and neuromuscular disorders including cerebral palsy, multiple sclerosis and muscular dystrophy. In previous years neurological research was unfocused. Since the resolution of neurological disorder problems through rehabilitation will greatly contribute to the understanding of many other difficulties experienced by the severely disabled, RSA's current R&D strategy is to synthesize our efforts and give this problem area further attention.

In recent years the Rehabilitation Services Administration has supported short-term training courses in such areas as: (1) vocational rehabilitation methods for professional staff of local affiliates of the United Cerebral Palsy Association; (2) rehabilitation counseling techniques with the cerebral palsied client for the State Rehabilitation agency counselors; and (3) executive development for administrators of cerebral palsy programs.

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Number of Rehabilitants with Cerebral Palsy

Fiscal Year Ending June 30	Persons Rehabilitated	
	Total	Cerebral Palsy
1972	326,138	1,771
1973	360,726	1,991
1974	361,138	2,500
1975	363,000	2,900
1976	332,000	3,000

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

REPORT ON DAY CARE

A REPORT TO THE

HOUSE COMMITTEE ON APPROPRIATIONS

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Federal Funds Expended for Day Care
(Dollars in thousands)

	1974	1975	1976
SOCIAL AND REHABILITATION SERVICES:			
Assistance Payments Administration:			
Work Incentives Program	$ 47,780	$ 42,473	$ 43,691
Community Services Administration:			
Social Services	292,200	349,500	364,800
Child Welfare Services	1,841	1,841	1,841
Subtotal	294,041	351,341	366,641
Office of Planning, Research, and Evaluation:			
Research	-0-	1,324	1,068
Sub-Total, SRS	341,821	395,138	411,400
OFFICE OF HUMAN DEVELOPMENT:			
Office of Child Development:			
Head Start	1/	1/	1/
Research and Demonstration	3,500	3,500	3,500
Sub-Total, OHD	3,500 2/	3,500 2/	3,500 2/
OFFICE OF EDUCATION:			
Vocational Home Economics	1/	1/	1/
Education for the Handicapped	393	316	317
Sub-Total, OE	393	316	317
NATIONAL INSTITUTE OF EDUCATION	54	75	200
Sub-Total, NIE	54	75	200
TOTAL	$345,768 2/	$399,029 2/	$415,417 2/

1/ Estimates are not available on the portion of this program's budget supporting day care.

2/ Does not include amounts expended for day care where such service is ancillary to primary purpose of program, ie. Head Start and Voc. Home Economics.

Report on Day Care

(Fiscal Year 1976)

The Department of Health, Education, and Welfare funds several programs which provide day care services to children of working mothers. These include day care services under the Work Incentive Program (WIN), Social Services Programs, and the Child Welfare programs, all administered by Social and Rehabilitation Services. In addition Head Start administered by the Office of Child Development in the Office of Human Development, provides care during the day for many children from low-income families. Day care benefits of the Head Start program are ancillary to the major purpose of Head Start, which is the provision of comprehensive developmental services (educational, nutrition, health, social and psychological) to children and their families. The Vocational Home Economics program in the Office of Education also provides day care to many pre-school children as an outgrowth of its main purpose.

The Department of Health, Education, and Welfare also supports research and demonstration efforts to develop knowledge and stategies to assure that DHEW and other day care resources will be most effectively utilized to provide quality day care services meeting the needs of children, families and communities.

SOCIAL AND REHABILITATION SERVICE

Federal Funds Expended for Day Care

	1974	1975	1976
		(in thousands)	
Assistance Payments Administration:			
Work Incentives Program	$ 47,780	$ 42,473	$ 43,691
Community Services Administration:			
Social Services	292,200	349,500	364,800
Child Welfare Services	1,841	1,841	1,841
Subtotal	294,041	351,341	366,641
Office of Planning, Research, and Evaluation:			
Research	- 0 -	1,324	1,068
Total, SRS	341,821	395,138	411,400

SOCIAL AND REHABILITATION SERVICE

WIN Child Care

Assistance Payments Administration

The Work Incentive Program, authorized under Title IV of the Social Security Act, is a State-administered program designed to encourage and assist recipients of Aid to Families with Dependent Children (AFDC) to achieve self support through a program of training, work experience, employment, child care, and other supportive services. The 1971 Amendments to the Social Security Act authorized child care and other supportive services to be provided to all WIN registrants who need such care and services to enable them to accept work or training. State expenditures are matched by federal payments at the rate of 90 percent.

Child care services include full-time and part-time care for children of WIN participants. Child care may be in their own home, in family day care homes, and in day care centers. Of the child care provided in 1974, two-thirds was full-time and nearly one-third part-time. Child care for children in their own homes accounted for 51 percent of the total care provided, while 34 percent received care in family day care homes and 15 percent were cared for in day care centers.

	1974	1975	1976
Federal Funds.....	$47,780,000	$42,473,000	$43,691,000
Child years of care provided.....	80,700	71,625	71,625
Total children.....	260,300	275,400	275,400
Total WIN registration...	1,800,000	1,460,000	1,500,000

Community Services Administration

Day Care Services

The Community Services Administration has responsibility for administering the Social Services program authorized by Titles I, IV-A, VI, X, XI, XIV, and XVI of the Social Security Act as amended in 1972 as well as the Child Welfare Services program authorized by Title IV-B of the Act.

The 1974 Social Services Amendments to the Social Security Act (P.L. 93-647) establishes a new Title XX which authorizes grants to States for services to eligible individuals based on income. Except for the Commonwealth of Puerto Rico, the Virgin Islands and Guam, Title XX supersedes all authorizing Titles except Title IV-B, and is effective October 1, 1975.

Within the broad spectrum of services provided to eligible individuals are day care services to children and adults. The following types of day care are provided:

(1) In-home day care is provided through a homemaker service and by relatives, friends or neighbors.

(2) Out-of-home care may be provided in family day care homes, group day care homes and day care centers.

The child care services furnished must be suited to the age, special handicaps or other conditions of individual children and selected with the participation of the mother (or other responsible relative) insofar as possible.

State licensure laws and standards must be enforced to assure that child care facilities used by the agency are licensed or approved as meeting the standards of the licensing authority. All out-of-home care must also comply with the Federal Interagency Day Care Requirements.

In FY 1976 it is estimated that States will expend $364,800,000 in Federal funds through the Social Services program and $1,841,000 through the Child Welfare Services program to provide day care services to an estimated 703,000 individuals.

(Dollars in Thousands)

	1974 Estimate	1975 Estimate	1976 Estimate
Social Services.....	$292,200	$349,500	$364,800
Child Welfare Services.....	1,841	1,841	1,841

Office of Planning, Research, and Evaluation

DAY CARE

Following several years of activity in day care demonstrations for which projects have been completed, three projects will be approved in Fiscal Year 1975. One two-year project will demonstrate the effect of in-home-training to AFDC mothers who provide day care. A second project will be undertaken together with the National Science Foundation to demonstrate the effect of training day care providers through the use of two-way cable. A third project is aimed at improving the management of day care by developing systems of information and referral to provide an effective exchange between mothers, and utilization of day care slots.

(Dollars in thousands)

	FY '74	FY '75	FY '76
Research.....	- 0 -	1,324	1,068

OFFICE OF HUMAN DEVELOPMENT
Office of Child Development

The Office of Child Development (OCD), located within the Office of Human Development serves as an advisor to the Secretary, the Assistant Secretary for Human Development, and other Federal agencies on matters pertaining to the care and development of children.

Child development program efforts aim at improving child care delivery systems and designing programs to improve the quality of life for children and their families throughout the Nation. Major activities are focused on meeting the developmental needs of preschool-age children from low-income families and on improving services to particular populations of vulnerable children such as the abused and neglected, children in foster care, children in need of adoptive homes, and children in institutions. A variety of research and demonstration activities are also conducted. They are designed to improve the quality of children's programs, such as day care and emergency services, and to measure their impact on the children and families served. The three major child development programs are Head Start, Child Welfare, Research and Demonstration, and the Child Abuse and Neglect Prevention and Treatment Program.

Research and Demonstration
(Dollars in thousands)

	FY 1974	Estimate FY 1975	Estimate FY 1976
Research and Demonstration (Day Care)	$3,500	$3,500	$3,500

The aims of OCD's day care activities are to develop knowledge and strategies to assist in the effective utilization of Federal, State, local and private resources and in providing quality day care which satifies the needs of children, their families and their communities.

Current efforts are directed toward: (1) initiating experimental research on a number of key policy issues revolving around the cost of center-based day care; (2) reviewing and evaluating the results of a demonstration project on home-based care with a view toward developing and disseminating information to be used by various kinds of administering agencies interested in creating a network of quality family day care homes, (3) working with state and local licensing agencies in their review and improvement of local licensing codes and regulations using OCD's "Guides for Day Care Licensing" as a basis for this review; (initiating a parent survey using replicable survey instruments in order to provide some information about trade-offs parents are willing to make in choosing various kinds of day care; and (5) developing and disseminating informational material and "good practice guidelines" about day care.

All of the current efforts contribute toward the overall goal or achieving a better understanding of the needs of the children who are in Day Care as a basis for providing quality Day Care, taking into account a variety of factors including costs. The results of several of the projects initiated during FY 1974 including, the day care cost-effective study and the parent survey, will provide data essential for activities having a direct impact on this goal.

The day care cost-effectiveness experience will involve about 1,800 children and their parents and about 150 caregivers. The intended beneficiaries would be the consumers and providers of center-based day care. Accurate data is not available on the number of licensed day care centers currently operating, but the best estimate is that 720,000 children are served by those centers.

The Family Day Care Home Study involved 6 different grantees working with a total of 240 family day care homes, and about 1440 children. Although accurate data is not available on how many children are served by existing family day care homes, the best estimate would be about 195,000 which should increase substantially by 1980.

Although much general information is available in the field of day care, a need exists for more specific usable information designed to aid the providers of day care at the Federal, State and local level in their efforts to deliver quality day care at reasonable cost levels.

In this regard, there is a need for more specific information about the benefits that children and parents derive from various day care programs and services as related to the cost of providing such programs and services. Information of this type is particularly important because policy makers at all levels of government as well as practitioners need this type of information to develop the best possible day care programs for the children at the lowest possible cost to the consumer. Little careful research has been performed on the relationship between major cost variables in day care, such as the ratio of center staff to children and the level of professionalism of a center staff, to benefits derived by children in a day care center.

Another need exists in the area of parent perceptions of what they consider to be important to their children in day care. Little reliable information exists to describe current usage patterns and different consumer preference patterns among various groups using day care, the actual and perceived barriers to the use of different kinds of day care, and the tradeoffs parents would make between various levels of service and costs and between different types of arrangements and localities. The quality and utility of this type of information would be increased by developing a survey instrument for obtaining this information on a periodic basis so that policy makers and practitioners in the field of day care not only could more sharply focus the type of day care needed for specified target populations but also could be alert to changes in the needs and desires of these populations.

Head Start
(Dollars in thousands)

	FY 1974	FY 1975	FY 1976
Head Start Total.....	$392,100	$414,300	$434,300

Head Start is a comprehensive preschool program which serves children and their families, primarily those who are poor. It encompasses a wide range of development activities including education, medical, dental, nutritional, social and other services with particular emphasis on parent involvement. Head Start funds full-year and summer programs. The full-year programs provide service either on a full-day or part-day basis. A variety of training and technical assistance activities are provided to local program staff to enhance the quality and effectiveness of the services offered. Head Start also conducts experimental programs such as the Child and Family Resource Program which provides family-oriented child development services according to the assessed needs of individual children, and Developmental Continuity, a program to facilitate continuity of educational and social gains made in preschool programs into elementary school.

For FY 1976 Head Start will assure that 10 percent of the enrollment opportunities in each State are available to handicapped children. This is in accordance with the legislative mandate contained in P.L. 93-644. Prior to FY 1976 Head Start had implemented a policy of making 10 percent of the enrollment opportunities nationwide available to handicapped children. Head Start now serves handicapped preschool children in an integrated setting with the non-handicapped and has established service delivery linkages with State and local agencies concerned with handicapped children.

Grants to carry out the Head Start program are awarded to public and private non-profit agencies. The agencies so funded must meet established criteria for receiving Federal funds. Grants to operated Head Start centers are based on an 80 percent Federal share and a 20 percent non-Federal share. Project grant activities are administered by HEW regional offices in accordance with national policies.

The Head Start Policy Manual states that the appropriate duration of an educational or enrichment program for pre-school children is no more than six hours per day. Beyond this period, it is desirable for a child to "return to his own family unless there is no suitable caregiver in the home due to employment, illness or other reasons." Only in such cases may the basic Head Start program be supplemented to provide full day care for the child.

Low-income children and families, like other segments of the community, differ greatly in their need for child care and developmental services. Ideally, Head Start programs should be tailored to the special and diverse needs of each individual community and child, with particular emphasis placed on serving those with the greatest need. Thus, size permitting, each Head Start program should provide a balanced program of remedial and developmental services that reflects the full array of needs in the community

The following tables reflect budget and program data for the entire Head Start activity. Budget and program data specifically related to day care are not available.

Budget Data	FY 1974	FY 1975	FY 1976
Subactivities:			
a. Full-year and summer	$357,692,000	$379,892,000	$399,892,000
b. Experimental program	6,000,000	6,000,000	6,000,000
c. Career development and technical assistance	19,150,000	19,150,000	19,150,000
d. Evaluation	3,000,000	3,000,000	3,000,000
e. Parent and Child Centers	6,258,000	6,258,000	6,258,000
Total	$392,100,000	$414,300,000	$434,300,000

Program Data	FY 1975		FY 1976	
	Number of Children	Average Cost per Child	Number of Children	Average Cost per Child
Full-Year Head Start	288,000	$1,278	288,000	$1,345
Summer Head Start	46,000	257	46,000	270
Experimental	11,000	---	11,000	---
Parent and Child Centers	4,000	$1,564	4,000	$1,564
Total Children Served	349,000		349,000	

Office of Education

Report on Day Care

The Office of Education's role in providing day care services is limited to aspects of vocational home economics education and education for the handicapped programs. The day care role within these activities is focused on training workers for day care/child care occupations and providing services to handicapped children through the support of special demonstration projects. Moreover, such day care services are segments of broader program activities.

Vocational Home Economics

The Vocational Education Act of 1963, Part F, Consumer and Homemaking Education, as amended, provides grants to States for educational programs which prepare youths and adults for homemaking and wage earner roles. An ancillary function of the Act and a general objective of vocational home economics education is the training of personnel to operate child care/day care development centers. Such training represents one component of comprehensive child care development programs. The day care courses are furnished in home economics in-school laboratories and centers which perform the dual role of training potential child care/day care workers and providing a conducive atmosphere for the growth and development of preschool children. Programs are developed on the local and State level with national technical support. Coursework may include training in child care and development occupations, infant, toddler and school age care, child nutrition, program planning, working with parents, foster family care, administration and supervision.

Since day care personnel training is part of comprehensive child care training programs which vary in scope according to locality, a breakdown of obligations specifically for day care courses is not feasible. Funding for child care development is made available under Consumer and Homemaking Education grants which in fiscal year 1974 and 1975 was supported at $30,994,000 each year. In fiscal year 1976 support for all activities previously authorized under the Vocational Education Act is being requested under new proposed legislation.

Enrollment in child care programs has increased from 8,453 students in fiscal year 1967 to 83,202 in fiscal year 1973. In some States enrollment has more than tripled between fiscal year 1970 and fiscal year 1973. The State of Washington has seen an increase form 1,734 students in fiscal year 1970 to 8,509 in fiscal year 1973. These figures represent enrollment in all child care development programs of which day care training is one component. In fiscal year 1972, the latest year in which figures are available, approximately 375,000 preschoolers received either direct or incidental day care services through vocational home economics child care programs.

Examples of day care related vocational education programs benefiting preschoolers, students and parents and society are:

Everett Community College - A parent cooperative which sponsored a preschool day care facility for children of welfare recepients also provided classes for 140 welfare mothers in parent education. The existance of the day care center permitted 65 of the mothers to assume either full or part time employment. Thirteen of the participants obtained General High School Equivalency diplomas after completion of the program. Federal funds expended were $61.00 per mother per year which resulted in all participants being removed from the city's welfare case load and increased the earnings potential of the thirteen who completed high school equivalency training by an average of $15,000 per individual per working lifetime.

In Albuquerque, New Mexico, a high school with a predominately Spanish surnamed American student population and a 40% dropout rate, commenced a child care development program for ninth graders in fiscal year 1970. Working with the preschoolers raised the students own self concepts and resulted in only 2% of the 60 participants failing to graduate by the conclusion of the program.

Education for the Handicapped

The Handicapped Children's Early Education Program, Part C, supports demonstration preschool projects which are designed to stimulate the development of comprehensive educational services for handicapped children from birth through age 8 and their families. Several projects supported under this authority are located or cooperate with day care centers and programs. The day care services provided are often incidental to the specialized education provided. The following projects furnished either direct or indirect day care services to handicapped children.

The Children's Circle Workshop, Bronx, New York, served 165 children from fiscal year 1972 to fiscal year 1976. One hundred children were screened and 95 staff members were trained. In fiscal year 1972, $100,000 was obligated for this project, in fiscal year 1973, $50,000 and in fiscal year 1974, $59,830. Money was not requested in fiscal year 1975 or fiscal year 1976. The last year of support, fiscal year 1974, provided outreach training and resource help to other day care programs to enable them to enroll handicapped children and provide special educational services to meet their needs.

The Clark County Board of Education, Athens, Georgia, represented a jointly funded project of the Handicapped Children"s Early Education Program and Model Cities. The program provided incidental day care services to 107 children from fiscal year 1972 through fiscal year 1974, screened 250 children and trained 153 staff members. The project was funded at $24,313 in fiscal year 1972, $67,193 in fiscal year 1973, and $82,944 in fiscal year 1974. Funds were not requested in fiscal year 1975 and fiscal year 1976.

The National Capital Day Care Association, Inc. of Washington, D.C., has been funded to develop a three year demonstration project concerning specialized programming for preschool handicapped children. From fiscal year 1973 through fiscal year 1974, 55 children participated, 300 children were screened and 65 staff members trained. In fiscal year 1973, the project was funded at $59,897, in fiscal year 1974, $100,000, and in fiscal year 1975, $106,000. The fiscal year 1976 funding estimate is $60,000.

The National Urban League has been funded to demonstrate the possibility of developing a network of day care programs which would integrate handicapped children and non-handicapped children. From fiscal year 1972 through fiscal year 1974, 148 children participated, 300 children were screened and 75 staff members trained. In fiscal year 1974 the three sites in existance were San Francisco, California, Columbia, South Carolina, and St. Paul, Minnesota. In fiscal year 1972, the project was funded at $250,000, in fiscal year 1973 a time extension was granted with no additional funds provided. In fiscal year 1974 and fiscal year 1975, $150,000 was obligated each year. For fiscal year 1976, $150,000 funding is being requested.

The Saginaw, Michigan Child Development Center has been funded to develop a demonstration day care program to serve emotionally and mentally handicapped children so they may be assimilated into the public school system. In fiscal year 1975, 20 children have been served and $60,000 obligated for the project. For fiscal year 1976, 107,000 is being requested to expand the pilot program.

Obligations for Projects Providing Direct and Indirect
Day Care Services under The Handicapped Children's Education Program

Project	1972 Actual	1973 Actual	1974 Actual	1975 Estimate	1976 Estimate
Children's Circle Workshop..	$100,000	$ 50,000	$ 59,830	$ ---	$ ---
Clark County Board of Education 1/.....	24,313	67,193	82,944	---	---
National Capital Day Care...	---	59,897	100,000	106,000	60,000
National Urban League.....	250,000	---	150,000	150,000	150,000
Saginaw, Michigan, Child Development Center.....	---	---	---	60,000	107,000
Total.....	374,313	177,090	392,774	316,000	317,000

1/ Jointly funded with Model Cities.

NATIONAL INSTITUTE OF EDUCATION

DAY CARE REPORT

	FY 1974	FY 1975	FY 1976
	($ in thousands)		
Child Study Center, Washington, D.C.	$54	$75	$200

The Center has been supported as a facility for NIE staff to conduct research on the learning and development of pre-school children of federal employees. Alternatives designed to increase the impact of the research expenditures will also be explored, such as establishing a pre-school demonstration site in collaboration with the Smithsonian Institute.

DRUG ABUSE

(Obligations)
(In thousands)

	1972	1973	1974	1975 Estimate	1976 Estimate
Public Health Service:					
Alcohol, Drug Abuse, and Mental Health Administration					
National Institute on Drug Abuse.....	$116,675	$181,283	$273,900	$211,011	$221,858
Office of Education:					
Drug Abuse Education....	12,400	12,000	6,700	0	0
Elementary and Secondary Education, Title III..	1,300	1,600	1,600	1,400	800[1/]
Higher Education.....	95	106	100	0	0
Subtotal, Office of Education.....	13,795	13,706	8,400	1,400	800
Social and Rehabilitation Service:					
Community Services Administration.....	[2/]	37,852	41,600	47,800	55,000
Office of Human Development:					
Rehabilitation Services Administration:					
Basic State grants....	5,040	7,068	8,190	10,880	12,920
Expansion grants.....	348	431	377	---	---
New career grants.....	135	125	---	---	---
Rehabilitation training.....	395	92	---	---	---
Rehabilitation research and demonstrations..	652	790	137	303	193
Special foreign currency program.....	---	---	18	50	210
Subtotal.....	6,570	8,506	8,722	11,233	13,323
Total.....	137,040	241,347	331,622	271,444	290,981

1/ Federal support for Title III will be included in a new consolidated education grant legislative program

2/ Obligations not identifiable

Drug Abuse

Introduction

Heroin abuse emerged in the middle 1960's as a problem of major significance. Domestically, estimates of the extent of heroin abuse at one point reached beyond 630,000 addicts and users. Available data reveal that heroin addiction remains a national problem with evidence of its use increasing in some areas of the country. At the same time, patient enrollment in NIDA funded treatment programs has grown from 55,629 in December 1973 to essentially maximum capacity of 95,000 as of March 1975. These signs do not provide an occasion for any slackening of effort. Heroin continues to be our number one drug priority.

With respect to the non-opiate drug category, the abuse of barbituates, amphetamines, hallucinogens and cocaine remain as areas of concern for us. The extent of non-medical use of barbiturates and amphetamines is difficult to estimate. The barbiturates, sedative hypnotics, amphetamines and related stimulents problem is not confined to use of drugs obtained from illicit traffic. We believe that the social costs related to the abuse of these substances can be minimized through continuing availability of treatment, appropriate education efforts, and informing the medical profession about the abuse potential when prescribing these substances.

The use of hallucinogens is a relatively recent development in the United States. There is a general agreement among those in touch with treatment and crisis centers that the popularity of hallucinogens continues to decline; however, definitive data to confirm or dispute this concensus are difficult to obtain because of its unpredictable effects. The social costs of hallucinogen abuse relate primarily to this unpredictability which can range from overdose to the precipitation of narcotic or depressive episodes, even for those who have used these substances previously without such effects.

While it is convenient for the purposes of discussion to consider each of the primary drugs of abuse separately, most involved drug abusers using several different drugs not just individually but in combination. Patterns of multiple drugs of abuse - also referred to as polydrug abuse - include either drug substitution or the use of several drugs simultaneously. These patterns of multiple drug use make it difficult to assess the size of the problem. While we may be able to estimate the number of abusers of each substance, the overall estimates are not necessarily conclusive since a single individual may be counted in more than one group. We can say, however, that there continues to be an increase in the number of multiple drug users.

PUBLIC HEALTH SERVICE

Alcohol, Drug Abuse, and Mental Health Administration

National Institute on Drug Abuse

Fiscal year 1975 has been a pivotal year for NIDA in that the federal effort began to shift from the development of a national drug abuse treatment network to activities assuring that a uniform high quality level of treatment service be provided nationwide. This refocusing will continue on a broader scale in FY 1976 with the Institute increasingly involved in the transfer of direct operational responsibility for treatment and training programs from the federal to state sector. Concomitantly, the Institute will continue to develop its national coordinative role and, in doing so, emphasize completion within the states of the Integrated Drug Abuse Information System (IDAMIS); the start-up costs of which have already been borne by NIDA. While the initial elements of the system focus on assessing treatment utilization and inventorying available facilities, FY 1976 will see implementation of those elements of the system which will provide data on the national cost aspects of drug abuse.

The primary treatment objective will be to maintain the 95,000 treatment slots originally established in FY 1974 for which full utilization was realized early in 1975. While direct administrative responsibility for treatment will continue to shift to the states through large statewide service contracts and state formula grants, the Institute will be involved with the development and review of plans and recommendations on third party coverage of treatment costs. At least partial coverage of treatment under this mechanism will be a major NIDA goal over the next several years. In addition, NIDA will be assisting the states in developing training curricula and standards for the credentialing of treatment personnel and the licensing of drug treatment. NIDA will support these activities through the National Training Center. In this manner, FY 1976 will witness a major redirection of the Institute efforts in strengthening the state's capability to provide treatment for the training in the phenomenon of drug abuse. Research will continue to focus on both basic and applied areas of study with particular emphasis on large scale clinical tests of naltrexone, a relatively long acting, non-habit forming narcotic antagonist which appears to be both therapeutically effective and clinically safe. Final clinical testing of LAAM a long acting substitute for methadone, will take place.

Summary Objectives for FY 1976

Personnel engaged in general program direction and those involved with training, information, and treatment program management will increasingly work with the state sector to provide the technical assistance necessary to allow them to assume a more substantive role in the direct administration of these programs. With essentially full utilization of NIDA's treatment slots effected, a special emphasis will be placed on refinement of services available and adjusting individual capacities as necessary to assure maximum efficiency in the national treatment efforts. Effective use of third party payments and investigation of the implications and applicability of national health insurance proposals will also be a major consideration in FY 1976. In addition, an increased emphasis will be placed on program evaluation and the international aspects of drug abuse, two important areas necessarily limited in past years due to the urgent need to establish a national drug abuse program. Emphasis in training will focus on the development of a national training system under the leadership of this National Training Center.

TREATMENT

Treatment activities center on the development and maintenance of service programs for drug abusers. In FY 1976 priority attention will be directed toward preparing state and local agencies to become the primary focus of future direct treatment activities. The three major long-range goals of the Institute will continue to be: (1) maintenance of the current level of federally funded treatment capacity until the demand for treatment abates and/or the states can accept their full responsibilities; (2) development of national treatment standards for controlling both quality and efficiency of treatment; and (3) increasing technical assistance to the states to help them assume an increase in treatment responsibilities as rapidly as possible.

The FY 1976 budget request for treatment programs is adequate to support the existing level of NIDA funded treatment capacity with some modification to the current formula of matching continuations. Expressed in terms of static capacity, i.e., the number of patients that can be treated at any one time, the Institute will be providing full or partial support for approximately 95,000 treatment slots. Although the length of a treatment program can vary considerably from individual to individual and program to program, it is estimated that about 161,500 patients will again receive treatment in federally supported projects in FY 1976. This will allow the Institute to continue to play a major role in meeting the drug abuse demands of the nation. Some shifting of funded treatment capacity among communities is planned so that resources which are not being adequately utilized in one area can be shifted to another in which there is an unmet need.

Treatment programs fall into four major categories. The first, assisting communities to establish treatment programs for narcotic addicts and drug abusers through the awarding of grants, is funded under the provisions of the Community Mental Health Centers Act and the Drug Abuse Office and Treatment Act of 1972. Programs in the second category utilize the contract mechanism available under the DAOT Act primarily to establish statewide contracts under which individual projects are subcontracted by the states. The third category is a civil commitment program conducted under Titles I and III of the Narcotic Addict Rehabilitation Act (NARA) and is totally funded and operated by the Federal Government. The forth category represents the Institute's efforts in drug abuse prevention and education. These categories are described in detail below.

The Community Assistance Grant Program

Staffing Grants (Sec. 251, CMHC Act)

Staffing grants provide funds to pay a portion of the salaries of treatment personnel in drug abuse treatment centers. Only 24 of these staffing grants are now in existence because the newer drug abuse service project grants are more desirable from the recipient's viewpoint. No additional grants were awarded in FY 1974 under this authority and no new awards are planned for FY 1975 or FY 1976. The federal funding level of these programs in FY 1975 will be approximately $11,001,000 providing treatment capacity for 11,042 patients.

Drug Abuse Service Project Grants (Sec. 410, DAOT Act)

Drug abuse service project grants are awarded on a matching fund basis for the total operational costs of projects for the treatment of narcotic addicts and other drug abusers. To obtain an award a program must offer one

or more of the following services: detoxification, institutional, or community-based aftercare. Since the funding of the initial 16 projects at the end of FY 1971, this program has expanded to its current total of 187 projects. The current federal funding level for this program is $72,327,000 providing a treatment capacity of 52,942 patients. Ninety-nine of the programs are supported by the Community Mental Health Centers Act and provide support for eight years. The remaining 86 projects were funded since April 1973 under the Drug Abuse Office and Treatment Act and are eligible for three years of federal support with possible renewal for an additional three years. As indicated by its rapid growth, this program has been the mainstay of the community assistance grant effort. In FY 1976 the emphasis of this program will be on maintaining the quality of services with available funds, and new or renewal projects will be funded only in so far as necessary to maintain the 95,000 treatment slots.

Formula Grants (Sec. 409, DAOT Act)

These awards are made under the authority of Section 409 of the Drug Abuse Office and Treatment Act, being first available in FY 1973. Financial assistance is provided to the states for planning, establishing, conducting, and coordinating projects for the development of more effective drug abuse prevention functions in the state and for evaluating the conduct of such functions. Funds are allocated to states based on a formula which measures the relative population as well as the financial and program need of each state. Federal funding through the formula grant mechanism will be maintained at $35,000,000 in FY 1976. A recent nationwide survey has shown the states are utilizing their formula grant funds in approximately the following manner: (a) 13% for treatment and rehabilitation programs; (b) 45% for prevention and education programs; (c) 19% for training efforts; (d) 9% for research initiatives; (e) 4% for program evaluation; and (f) 10% for administration. In FY 1976 formula grants will continue to serve as the mechanism through which states will assume coordinating responsibility for their drug abuse programs.

Demonstration Treatment Grants (Sec. 410, DAOT Act)

The purpose of these grants is to support and evaluate treatment projects which demonstrate effective methods of delivery services; to permit advance intelligence on new modes and means of drug abuse and addiction treatment; and to provide appropriate services to meet the new and existing problems related to substance abuse. These projects are for a maximum of three years and may be supported by up to 100% federal funds. The first three of these projects were awarded in FY 1972 and this year 27 projects will be funded at a level of $11,759,000. A similar level of support will be maintained in FY 1976. Specifically, in FY 1976 attention will be placed on demonstration projects designed to test innovative treatment techniques for potential replication at the operational level. Special emphasis will be given to the development of innovative aproaches for the treatment populations with special treatment needs (e.g. Indians, the aged, and adolescents), the development of innovative ways to get drug abusers into the economic mainstream, and evaluation of existing procedures and techniques in the treatment of the drug abuser.

The Statewide Services Contract Program
(Sec. 410, DAOT Act)

This program is a cost-reimbursement, cost sharing, contractual mechanism through which the Institute can fund a number of drug treatment projects under the "umbrella" of the Single State Drug Authority. This program began in FY 1973 with contracts being let to the States of New Jersey, New York, and

Texas. Currently the mechanism is operational in twenty states and it is anticipated that this number will increase to 26 in FY 1976. Subcontracts are let by the state to support local treatment projects which have basically the same objectives and requirements as the drug abuse service projects grants. This program is the primary mechanism by which states assume greater direct treatment responsibility for their drug abuse projects. The continued growth of the programs is evidence of the Institute's efforts to consolidate as many programs as possible at this local level. Funding for the program will increase from $31,750,000 in FY 1975 to $39,630,000 in FY 1976 with total treatment capacity enlarging from 20,997 to 25,898 slots.

The Rapid Expansion Contract Program
(Sec. 410, DAOT Act)

This program provides for the rapid expansion of treatment facilities to treat drug abusers on a fee-for-service contract basis. These contracts were let, during the time when NIDA was establishing the basic 95,000 treatment slots, to agencies who could substantiate significant unmet treatment needs in their communities. The contracts were always made with or through the individual state drug abuse authorities. At the end of FY 1973, the peak year of this program, there were ten projects funded for a total of $7,850,000 providing a treatment capacity for 4,703 patients. With the absorption of the OEO rapid expansion contracts in August of 1973, the level of this program more than doubled. Since these programs were not by nature long term projects, it has been NIDA's continuing objective to merge the projects into the statewide contracts. This effort will virtually be completed in FY 1975 with only one of these contracts continuing to receive support totaling $887,000 for 563 treatment slots. It is anticipated that this project will be merged into a statewide contract in FY 1976.

The NARA Contract Program
(NARA Act)

Approximately 12,000 patients have received treatment under this civil commitment program since its inception in 1966. In the past, the inpatient phase of the program was conducted at the Clinical Research Center in Lexington, Kentucky, or the Center at Fort Worth, Texas. Now that the treatment aspect of these facilities has been transferred to the Justice Department, all future services are being performed contractually at community facilities. There are currently 28 community-based agencies providing evaluation and examination, inpatient care, and supervised aftercare under contracts administered by the Institute. The present patient population in the civil commitment program is 535 persons. Efforts are currently being directed toward the integration of NARA agencies with community-based projects at the community mental health centers, with independent drug abuse service projects, and with the statewide contracts. New civil commitments are diminishing each year and program support will continue to decrease during FY 1976. Necessary funds for this program decreased from over $7,000,000 in FY 1972 to $1,334,000 in FY 1975 and only $1,000,000 is budgeted in FY 1976 in expectation of a continuance in the trend.

Education/Prevention Grant
(Sec. 410, DAOT Act)

Currently there are twenty-three acting projects funded in this area with a similar level of effort anticipated in FY 1976. This program is centered around the following primary goals: development of national policy governing

drug abuse prevention/intervention efforts, including comprehensive guidelines for the use of Single State Agencies and community planning groups; identification, evaluation, and support of model approaches to drug abuse prevention which promise to be effective and adaptable to wide application; nationwide dissemination of pertinent research findings, policies and guidelines, and evaluations within the field. Current programs include a project testing senior citizens as effective drug abuse prevention counselors for 5th and 6th grade children; a youth alternatives program in a disadvantaged community; a family communications program for parents of high-risk adolescents using trained community leaders; and development of increased drug abuse awareness among in-service teachers.

Summary Objectives for FY 1976

NIDA will continue to shift treatment service resources from project grants to statewide service contracts wherever possible. However, in order to assure that the current 95,000 federally funded treatment slots are maintained, it will be necessary to fund some new or renewal awards. Technical assistance to the states will be increased in order to prepare them to rapidly assume an increase in prevention responsibilities. National treatment standards for controlling both quality and efficiency of treatment will also be developed. Some shifting of funded treatment capacity among communities is planned to more effectively utilize resources. The current level of effort in demonstration and education/prevention activities will be maintained to insure a balance services program. In regard to formula grants, states will be encouraged to address the problem of quality care in their treatment and rehabilitation centers. Additionally, they will begin to play a greater role in developing policy for third-party payments in the treatment of drug abuse and expand their coordination of the various drug related services within their state.

RESEARCH

The National Institute on Drug Abuse supports a wide spectrum of extramural research projects on problems associated with drug abuse - from investigating psychosocial and epidemiological factors influencing drug abuse to studying the basic chemistry of abused substances. In addition to sponsoring research through grants to non-profit research organizations, contracts are awarded on a competitive basis for directed research when there is insufficient interest in the scientific community to generate acceptable grant applications and/or when research tasks focus on specific critical problems.

Narcotic addiction poses many questions which can be answered through research. For example, basic research on the mechanisms of opiate action was successful in identifying the locations in the brain where various narcotic drugs have their effect. During the past year, major new methodological advances have been achieved which enable investigators to actually visualize, through radioautography, the distribution of opiate receptors in the brain and other tissue. These findings offer possibilities for the development of more effective, longer-lasting narcotic antagonists which are relatively free of side effects and block the action of opiates without themselves being addictive. Major research programs are described as follows:

1. Development of Improved Therapeutic Knowledge for Treatment

   Existing chemotherapies are being improved by the development of l-alpha-acetyl-methadol (LAAM) and Darvon-N for use in maintenance therapy. Their long duration of action provides possible alternatives for some users of methadone and, consequently, will aid in reducing its diversion to unintended uses and the number of overdose deaths. Studies on naltrexone, an experimental therapeutic drug which blocks heroin effects, are continuing in several clinics across the country. These studies will permit the development of a more effective course of treatment which will assist addicts in achieving abstinence. Acupuncture is being tested to determine its efficacy, if any, in detoxifying addicts. Investigations on behavioral procedures, based upon research in operant conditioning, psychopharmacology, and psychophysiology, also provide knowledge which has been translated directly into treatment procedures for opiate addiction.

2. Study Socio-Cultural Family and Personality Variables

   Socio-cultural family and personality variables are studied to determine those which may contribute to preventing or encouraging drug use in groups known to have above average risk of serious drug abuse involvement. Resources may then be employed to effectively influence these variables to aid in drug abuse treatment, rehabilitation, research, and other prevention efforts. One research study on marihuana use by adolescents has determined that the influence of peers upon a person's drug use is much more powerful than that of parents. A sample of 8,000 students showed a 92% usage rate among youth with friends using marihuana, compared to only 7% usage among those without friends engaging in marihuana use.

3. Epidemiology

   Extensive data on the incidence and prevalence of drug abuse has begun to clarify usage patterns and trends in different age groups and in a variety of special populations. In FY 1976 a major new

initiative will be undertaken which will use nationwide data in predicting drug abuse outbreaks in individual states, while other studies will investigate drug abuse experience in the United States over time in order to detect changes in incidence at the earliest possible date. The epidemiology program will continue its follow-up studies on Vietnam veterans and other projects devoted to examining the geographical shifts in incidence of drug abuse.

4. Neurophysiological Mechanisms

Several investigators have made significant progress in establishing the complete chain of causality between the combination of a drug with its specific receptor and the resulting pharmacological effects in the organism. In case of opiate narcotics, this research seeks a better understanding of the mechanism responsible for the development of tolerance and dependence on these drugs and will lead to improved methods of drug abuse prevention, early intervention and treatment.

5. Adverse Effects of Drug Use

Increased emphasis is being placed on programs of preclinical toxicological evaluation of therapeutic drugs and drug delivery systems in order to determine their possible adverse side effects. Research continues to assess the adverse effects of drugs such as marihuana and cocaine, and deleterious effects of polydrug interactions. Research on long term use of marihuana is focusing on recent reports of hazardous effects of marihuana on DNA (a most important carrier of genetic information in cells) as well as the possible behavioral and psychiatric effects of chronic use of this drug. Of high priority will be the evaluation of hazards of marihuana use on very young adolescents during the post-puberty period of maximal psychological and biological change. Although such individuals cannot be used in experiments, survey methodology follow-up studies can be employed to assess the impact of use at this early age and its consequences on later life.

6. Chemistry and Metabolism

The development of improved methodologies for detecting drugs of abuse in body fluid and tissues continues to be an important area of study. The development of automated methodology for routine analysis, as well as the development of highly sensitive quantitative methods for research use, will provide more reliable information on the extent and nature of drug abuse.

7. Clinical/Biomedical Centers

Centers of research excellence are supported where the efforts of the basic and clinical researchers are integrated. In this way, the period required for the clinical application of basic research findings can be shortened. Research on the narcotic receptor in one of these eight centers already shows promise of improving present methods of prevention and therapeutic intervertion.

In addition to its grants and contracts program, the Institute supports the operation of the Addiction Research Center (ARC) in Lexington, Kentucky.

Research activities at the Center are directed primarily at the nature of the addictive process and at assessing the abuse potential of narcotic depressants, stimulants, and hallucinogens in an attempt to identify addicting drugs early and, through appropriate control, limit their abuse. ARC operations include identification of narcotic antagonists that may have potential usefulness in the treatment of heroin addicts; validity of chemical methods for detecting drug use and dependence; and the behavioral and biological basis of addiction.

Summary Objectives for FY 1976

During FY 1976 NIDA will complete the clinical testing phase of the continued investigations into LAAM (long-acting methadone), begin clinical testing of Darvon-N as a narcotic substitute, and undertake a major new national cooperative safety and efficacy evaluation of the narcotic antagonist naltrexone. Positive results from these investigations will result in a request to the Food and Drug Administration for clearance to permit regular use of the drugs in treatment programs. In addition, special emphasis will be given to epidemiological studies designed to refine our estimates of the extent of drug abuse in individual states, as well as nationwide, and to allow for careful tracking of the estimates over a period of time in order to detect changes in incidence at the earliest possible date. Studies will also be initiated into the broad problem of the biological basis of addiction with emphasis on the neuroanatomical, neurophysiological, and neuropsychological bases for drug reinforcement. High priority will continue to be placed on research into the adverse effects of marihuana usage in order to further advance our knowledge of this popular drug.

TRAINING

The drug abuse training program seeks to ensure the availability of qualified manpower in treatment programs. As a major share of this responsibility is transferred to the various states, through the combined efforts of the Regional Training Centers and technical assistance by NIDA personnel, the Institute will concentrate upon augmenting the national training effort through such activites as designing training models for sparsely populated states, and developing criteria for assessment of work experience in terms of academic credit required for credential recognition. A total of 11,800 people received training in FY 1975. Principal mechanisms of support are as follows:

1. Grants: Training grants are awarded under the authority of the Public Health Service Act (Sections 301 and 303) to non-profit institutions for specialized training programs in the prevention and treatment of narcotic addiction and drug abuse. The training that medical students and students in health related areas receive on drug abuse is improved by increasing the knowledge of academic facility and by developing regular courses of instruction. Other programs support training of persons who come into direct contact with drug abusers as well as specialized in-service or short term instruction on treatment, rehabilitation, prevention, and evaluation of training methods. Training topics include pharmacology, urine surveillance, medical problems and patient care, treatment modalities and their management, and individual and group techniques for working with the addict. In FY 1976 support will again be limited to continuation funding of a select number of training grant projects with no new programs being initiated.

2. Research Fellowships: Under the provisions of the National Research Service Award Act of 1974 (P.L. 93-348) individual and institutional awards are authorized to provide degree-oriented training support for aspiring bio-medical and behavioral research manpower. Support for this program will be reduced from $148,000 in FY 1975 to $67,000 in FY 1976 and no new awards will be made.

3. Contracts: Contract funds support the operation of the National Drug Abuse Training Center in Washington, D.C. The Center continues to serve as a model for developing, validating, and testing training techniques and methodologies which have application for training workers in community drug abuse treatment, rehabilitation, and prevention programs. The Center provides limited training to federal, state, and local government officials, and other health professionals engaged in community programs to combat drug abuse. The primary effort of the NDATC in FY 1976 will be to support states in the development of their training capability by assisting with credentialing procedures, standard evaluation, training of trainers, and the implementation of their statewide training systems. Funds are not provided for continuation of the Regional Training Centers since it is anticipated that state programs will be sufficiently developed to preclude the necessity of continued support for regional centers. Contract funding in FY 1976 will, therefore, be limited to the $2,000,000 necessary to continue the operations of the National Training Center.

Summary Objectives for FY 1976

The National Drug Abuse Training will continue to develop and consolidate its role as the center of national training system in the field of drug abuse prevention and treatment. The funding of training grants will continue to be phased out and support for fellowships will be limited.

SCIENTIFIC AND PROGRAM INFORMATION

The Institute is the primary service facility in the Federal Government for the acquisition and dissemination of programmatic and technical information relating to drug abuse prevention activities. More specifically, the Institute is responsible for maintaining program and management information emanating from federal and state drug abuse prevention efforts and providing periodic and special reports and analyses for operational and planning purposes; developing drug abuse information systems for internal management and for use by other federal agencies, states and localities; and providing consultation to and liaison with other federal, state, and private agencies concerned with information programs on drug abuse. In addition, it plays the lead role in the generation of data analyses for use in implementation of the national drug abuse policy. The major subject areas into which this effort is divided is as follows:

National Clearinghouse for Drug Abuse Information

The establishment of the National Clearinghouse for Drug Abuse Information (NCDAI) was announced in March 1970 by the President in response to the critical national need for a focal point for accurate and reliable information on drug abuse. At that time a number of drug abuse reporting mechanisms existed, most of which were related to programs totally or partially funded by the Federal Government. Since the existence and activities of these programs was already known, it was determined that all programs, federally, locally, and privately supported had to be identified in order to develop a total picture of the drug abuse treatment, prevention, and education services available throughout the country. The Clearinghouse operated as a central source for the collection and dissemination of drug abuse information within the Federal Government and served as a coordinating information agency for groups throughout the country involved in drug abuse programs. The NCDAI is the first federal agency to systematically organize and synthesize the mass of substantive data in the drug abuse field into an operational computerized information storage and retrieval system. The NCDAI system features abstracts or descriptions of books, pamphlets, journal articles, posters, films and other audiovisual materials as well as addresses of drug abuse treatment and prevention programs. Major components of the NCDAI follow below.

Resources and Materials File (RMF)

This file contains abstracts of documents and audiovisual materials. Scanning of the biomedical, pharmacological, social and behavioral science literature in addition to more popular and unorthodox publications such as the underground press is conducted on regular basis.

Clearinghouse Program File (CPF)

This file consists of identifying data on drug abuse programs across the country. The following elements are included: program name, street address, city, state, zip code, phone number, funding and program type. The file is searchable on the individual elements and various combinations of those elements. The information is updated on a continuing basis.

Drug Abuse Communications Network (DRACON)

This program serves as the vehicle through which decentralized access to drug abuse information can be provided so that regional needs may be met as

closely as possible to the source; the appropriate use of both national and local resources can be maximized; cooperation between drug abuse information resources can be increased; and truly responsive communications can be developed.

Integrated Drug Abuse Management Information System (IDAMIS)

IDAMIS is an information system designed to provide federal and state governments with timely and useful data on basic drug abuse phenomena, drug abuse treatment and prevention units, and related financial information. It is a series of three stand-alone subsystems, or modules, designed to provide the information required for intelligent and effective management decision making processes. These modules contain common identifying data elements necessary for the integration of the modules into one total comprehensive drug abuse management information system. The system is composed of the following three major or prime subsystems:

Client Oriented Data Acquisition Process (CODAP)

CODAP is designed to provide management with information on clinic administrative data (i.e., identification, funding sources, program linkages, and client capacities, etc.), clinic activity, client demography, treatment approaches, treatment summaries, first usage incidence, and other drug abuse phenomena. This information is, and can be, aggregated by many combinations of interest items at various levels of reporting, thus providing a wide range of useful data displays for management use. After extensive review, the final system was drafted and pilot tested in New York, Massachusetts, and California beginning in July of this year. National training began in September and full scale implementation was effective November 1, 1974.

Data is introduced by treatment programs across the nation via the CODAP Input Report Form, a five-part form containing reports on admissions, discharges, activity, client progress, and summary data on client flow. The form, with its Admission and Discharge Reports, provides information relating to the two most crucial points in the treatment process. The data derived from these two reports provides the major information output source of CODAP. The Activity Report provides the treatment process information essential to fulfill NIDA grant and contract specifications. The Client Flow Summary is a type of transmittal sheet, which along with the three prior mentioned reports constitutes the entire reporting system for most treatment units. The Client Progress Report is a specific requirement of the Bureau of Prisons for reporting the individual progress of their clients only.

Drug Abuse Prevention Resource Units (DAPRU)

DAPRU is the drug abuse inventory module of IDAMIS. Its objective is to construct and maintain a dynamic inventory of every drug abuse prevention unit in the United States, including trusts and territories. This portion of IDAMIS will provide accurate and current information on all types of drug abuse programs, regardless of funding.

DAPRU records the number, type, and location of all drug abuse prevention resources that exist within the United States. It also gathers information about these resources to provide a composite picture of the nature, type, and level of operation of each resource unit. In addition, it traces how units operating under a single organizational entity are linked to each other in terms of vertical administrative control as well as horizontal operational relationships. All of this information will be fed into a computer for ease

in updating and analytical report generation. The final inventory will contain information on treatment service units, administrative service units, central intake units, other treatment related units, training service units, education service units, information service units, and research service units.

The DAPRU system is being implemented according to a phase-in plan. A pretest was conducted in four states (September - October 1974) with the concept being enthusiastically received. The file is presently being established through the Single State Agencies. The computer software is being developed concurrently with the file initialization process so that it will be ready for a pilot installation in March 1975.

Financial Management Information System (FMIS)

The centralization of drug abuse management and funding responsibilities at the federal and state levels has established certain requirements for information to determine and assess the use of such funds. NIDA decided to design and implement a Financial Management Information System (FMIS) to support these requirements.

More specifically, the purpose of the FMIS is to support the capability of NIDA and the Single State Agencies to manage their block and discretionary grant and contract funds for drug abuse. The FMIS is intended to provide managers at the federal, state, and local program levels with information essential to: (a) program planning; (b) program monitoring and financial control, including grants and contracts management; (c) cost funding; (d) budget formulation and execution; (e) program analysis and evaluation. The FMIS is designated to supplement not replace existing systems and to support certain critical requirements that are, for the most part, not satisfied by existing systems. These include: (a) grants/contracts descriptive data on state-funded programs; (b) rates of expenditure on state and federally funded programs, including state formula grants; (c) income received by programs from third party payments; (d) functional cost information such as total program costs and costs per client in the various treatment settings and environments.

The FMIS system is currently reviewed by the states and in May 1975 a requirements definition study will be established in five selected states. Depending upon results, a systems demonstration project will be undertaken in the Fall of 1975 with subsequent implementation as soon thereafter as possible.

Integrated Drug Abuse Reporting Process (IDARP)

The Institute realized that many of the Single State Agencies did not have sufficient resources in the form of funds, manpower, or hardware (EDP equipment) to maintain the IDAMIS or any of its subsystems after installation. IDARP was initiated to assist the Single State Agencies in these efforts by providing funds for use in acquiring needed manpower, data processing services and hardware, and other related administrative expenses. The funds are provided by contracts to the Single State Agencies and presently all except one of the agencies have entered into these agreements. This virtually total acceptance of IDARP will help to ensure the effective establishment of the IDAMIS system.

Summary Objectives for FY 1976

The major effort will center upon assisting the states in assuming a more participatory and supportive position in the collection of vital information for the planning and management of the drug abuse problem. Through the

continued development of these information systems at the state level, the Institute's objectives of increasing the responsibility of the states and local programs will be further strengthened. In addition, work will be completed on the initial integration and coordination among the various sytems required to establish the national information system on drug abuse. This will help to ensure that drug abuse prevention resources are being effectively utilized and efficiently managed within the confines of state and federal requirements and regulations, and eventually will result in stardardizing information across state lines, permitting comparision of various jurisdictions and minimizing costs.

OFFICE OF EDUCATION

Drug Abuse Education

The Drug Abuse Education Act of 1970 (P.L. 91-527), enacted December 7, 1970, authorized drug abuse education demonstration projects in schools and communities and dissemination of information on drug abuse. The program was designed to alleviate the drug abuse crisis among youth by promoting awareness and understanding of the nature of the problem and developing and disseminating prevention and early intervention strategies aimed at attacking the causes of drug abuse rather than merely treating its symptoms.

P.L. 91-527 expired on June 30,1973. The program operated at a reduced level in fiscal year 1974 under a one-year extension of the Act. In September 1974, the Act was amended and extended through June 30, 1977 under P.L. 93-422. Initially, the program funded projects in 55 State and territorial education agencies to develop curricula and conduct in-service training programs for local education agencies and supported 57 local school, community, and college-based demonstration projects.

As experience with these and other projects accumulated, it became evident that virtually all communities have or could have some sort of drug problems, which vary widely in nature and scope from community to community. It became clear that a key factor in successful projects was coordination of the efforts of all segments of a community - family, school, church, social, health and civic agencies and local government.

It was deemed that the pervasiveness of the problem suggested that a realistic Federal role would be to provide training for school and community leaders to help assess and define their problems, state their goals in attainable and measurable terms, assess recommended strategies, methods and materials as tools appropriate to the realization of their particular goals and involve their communities in cooperative efforts.

In fiscal year 1973, in addition to continuing support for State education agency and demonstration projects, the program supported seven regional training and developmental assistance centers which provided two weeks of training and follow-up site assistance for 800 teams of five to seven individuals, bringing the total to approximately 1,700 communities served. In fiscal year 1974, an additional 240 community teams were trained, a nationwide program for training of and developmental assistance to 336 local school district teams in prevention and early intervention was initiated. Two models for the college level pre-service training of educational personnel were instituted. In one model, a total of 180 teams (900 administrators, faculty and students) from colleges of education were given three days of training and were provided follow-up assistance on request. In the other model, six projects for development and validation of pre-service training models were initiated.

No funds were requested for fiscal years 1975 or 1976.

Elementary and Secondary Education Title III, Supplementary Educational Centers and Services

Originally, the Commissioner made grants directly to local education agencies under Title III, ESEA, (P. L. 89-10). Beginning in fiscal year 1971, 85 percent of Title III funds were administered by State educational agencies, with fifteen percent to be used at the Commissioner's discretion.

The Title III State Plans program reported that over 83,000 students were in drug education classes in fiscal year 1972. These students were in 14 single component type projects and 26 multiple component type projects that studied the drug abuse problem. In fiscal year 1973, over 625,000 students were in drug education classes. These students were in 16 single component type projects and 30 multiple component type projects. It is estimated that the number of students served in fiscal year 1974 was about the same as in fiscal year 1973. It is expected that approximately 562,000 students will be served in fiscal year 1975 and approximately 310,000 students will be served in fiscal year 1976.

Higher Education Title I, University Community Services

Title I of the Higher Education Act of 1965 (University Community Service) pioneered the use of Federal funds to direct higher education resources toward the solution of the drug abuse problem.

In fiscal year 1973, seven (7) projects included 5,606 participants, and continued at about the same level as in fiscal year 1974.

A rescission of all budget authority for this purpose is proposed for fiscal year 1975. No funds are requested for this program in fiscal year 1976.

Community Services Administration

The Community Services Administration has responsibility for administering the Social Services program authorized by Titles I, IV-A, VI, X, XI, XIV and XVI of the Social Security Act, as amended in 1972.

The 1974 Social Services Amendments to the Social Security Act (P.L. 93-647) establishes a new Title XX which authorizes grants to States for Services to eligible individuals based on income. Except for the Commonwealth of Puerto Rico, the Virgin Islands and Guam, Title XX supersedes all of the authorizing Titles cited above and is effective October 1, 1975.

Within the broad-spectrum of services provided to eligible individuals are those directed at preventing, solving or alleviating the problems brought on by drug abuse. It is estimated that States will expend $55,000,000 in Federal funds through this program in FY 1976 on eligible individuals for services related to drug abuse.

OFFICE OF HUMAN DEVELOPMENT

Rehabilitation Services Administration

Unless drug abusers are provided those services which will allow them to prepare for, enter, and remain in gainful employment, the long-term success of drug abuse treatment programs will be questionable. State rehabilitation agencies are important resources for providing services such as vocational evaluation, work adjustment, vocational training, counseling, and placement assistance to eligible drug abusers. The experience gained in serving alcoholics and the mentally ill has been carried over to working with these clients.

State agencies are often unable to provide priority attention to drug abusers because these persons are usually able to obtain services from specialized drug treatment programs. The vocational rehabilitation program must meet the service demands of persons disabled by a wide range of conditions. For many of these people, especially the severely disabled, vocational rehabilitation is the only possible resource.

Within these constraints, State rehabilitation agencies are expected to continue to increase the number of drug abusers rehabilitated. This will be done in close cooperation with specialized drug treatment programs and with the single State drug abuse agencies established by PL 92-255.

Number of Drug Abuse Rehabilitants

Fiscal Year Ending June 30	Persons Rehabilitated	
	Total	Drug Abusers
1972	326,138	2,220
1973	360,726	3,600
1974	361,138	4,700
1975	363,000	5,800
1976	332,000	6,300

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

REPORT ON POPULATION AND FAMILY PLANNING ACTIVITIES

A REPORT TO THE
HOUSE COMMITTEE ON APPROPRIATIONS

PREPARED BY

THE OFFICE OF THE DEPUTY ASSISTANT SECRETARY
FOR POPULATION AFFAIRS
OFFICE OF ASSISTANT SECRETARY FOR HEALTH

MARCH 1975

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INTRODUCTION

This report describes the population research and family planning activities of the Department of Health, Education, and Welfare.

Population research and family planning activities in the Department of Health, Education, and Welfare include support of services--making family planning information and services available and accessible; training--meeting the professional and lay manpower needs in health, social services, and education; research--promoting and supporting research and research training in the biomedical and broad behavioral aspects of fertility, sterility, population dynamics and program implementation; and public education--increasing opportunities for sex education, public understanding of human sexuality, and information about family planning and population growth.

Family planning services, as an integral part of adequate medical care, have been routinely and easily available to the majority of the population. In his message to the Congress, President Nixon emphasized that "...no American woman should be denied access to family planning assistance because of her economic condition." Under the Social Security Amendments of 1967 (PL 90-248), subsidized family planning services are available through a variety of sources to some of those who want but cannot afford them. The Social Security Amendments of 1972 (PL 92-603) require that family planning services and supplies be made available under Medicaid to all individuals of childbearing age who are eligible under the State plan and who desire such services and supplies. In addition, the enactment of the "Family Planning Services and Population Research Act of 1970" (PL 91-572) assists in a major way in making comprehensive family planning services available to persons desiring such services.

Legislative Highlights - FY 1968 Through FY 1974

1. On January 2, 1968, the Social Security Amendments of 1967 (PL 90-248), which included the Child Health Act of 1967, were enacted. This Act established categorical project grants for family planning services and required that not less than six percent of the monies appropriated for Maternal and Child Health under Social Security Act (SSA) Title V be available for family planning services. This same legislation required that under SSA Title IV-A, the Aid to Families with Dependent Children (AFDC) program, family planning services were to be offered in all appropriate cases. Acceptance of such services was to be voluntary.

2. On December 24, 1970, President Nixon signed into law the "Family Planning Services and Population Research Act of 1970" (PL 91-572). This Act was passed to assist in making comprehensive voluntary family planning services available to all persons desiring such services.

3. On October 30, 1972, President Nixon signed the Social Security Amendments of 1972 (PL 92-603). This Act made

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it mandatory to inform all recipients of AFDC of the availability of family planning services and to provide or contract for services to all eligible persons desiring them. The Act imposes a penalty of one percent per annum on the Federal share of AFDC funds on States which fail to provide these services to eligible persons desiring them. In addition, the Act increases the Federal share of matching for family planning services under Title IV-A -- AFDC -- to 90 percent from 75 percent and increases the Federal share for family planning services under Title XIX -- Medicaid -- to 90 percent from a variable formula with a range from 50 to 83 percent Federal matching.

4. On June 18, 1973, PL 93-45 extended the funding authorizations in PL 91-572 one additional year to June 30, 1974.

The two tables that follow list some of the functions carried out by Department of Health, Education, and Welfare (DHEW) agencies.

Table 1 summarizes DHEW family planning programs for delivery of services by function, local delivery agency, and DHEW operating agency with funding and program responsibility.

Table 2 summarizes other DHEW population and family planning programs (research, training, education, and evaluation) by function and DHEW operating agency with funding and program responsibility.

Table I 7

DHEW Programs for Delivery of Family Planning Services
by Function, Local Delivery Agency, and DHEW Operating Agency

Function	Local Delivery Agency	DHEW Operating Agency with Funding and Program Responsibility
Medical Services, Information, Counselling, and Referral	Hospitals and Clinic Services	HSA[1/] -- Indian Health Service -- Bureau of Medical Services -- Bureau of Community Health Services ADAMHA[2/] -- National Institute of Mental Health SRS[3/] -- Medical Services Administration -- Community Services Administration
	Health Departments	HSA -- Bureau of Community Health Services SRS -- Medical Services Administration -- Community Services Administration
	Voluntary Health Agencies	HSA -- Bureau of Community Health Services SRS -- Medical Services Administration -- Community Services Administration
	Private Physicians	SRS -- Medical Services Administration -- Community Services Administration

1/ Health Services Administration
2/ Alcohol, Drug Abuse, and Mental Health Administration
3/ Social and Rehabilitation Service

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Table 1 (Cont'd)

DHEW Programs for Delivery of Family Planning Services
by Function, Local Delivery Agency, and DHEW Operating Agency

Function	Local Delivery Agency	DHEW Operating Agency with Funding and Program Responsibility
Information, Counselling, and Referral only	Public Assistance Agencies	SRS -- Community Services Administration -- Assistance Payments Administration
	Voluntary Social Agencies	SRS -- Community Services Administration -- Assistance Payments Administration
	Employee Health Services	HSA -- Bureau of Medical Services

Table 2

Other DHEW Population and Family Planning
Activities by Function and DHEW Operating Agency

Function	DHEW Operating Agency with Funding and Program Responsibility
Training Programs for Population and Family Planning	
1. Short-term Pre-service and In-Service Training of:	
(a) Physicians, nurses, other professional health personnel	HRA[1] -- Bureau of Health Resources Development HSA -- Bureau of Community Health Services ADAMHA -- National Institute of Mental Health CDC[2]
(b) Social workers and other public assistance personnel	SRS -- Community Services Administration -- Assistance Payments Administration -- Office of Research and Demonstrations ADAMHA -- National Institute of Mental Health
(c) Teachers	OE[3] ADAMHA -- National Institute of Mental Health
(d) Subprofessional workers	SRS -- Community Services Administration HSA -- Bureau of Community Health Services HRA -- Bureau of Health Resources Development OE -- Adult and Vocational Education

1/ Health Resources Administration
2/ Center for Disease Control
3/ Office of Education

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Table 2 (Cont'd)

Other DHEW Population and Family Planning
Activities by Function and DHEW Operating Agency

Function	DHEW Operating Agency with Funding and Program Responsibility
2. Curriculum Development for Above Programs	HRA -- Bureau of Health Resources Development SRS -- Community Services Administration OE
Research Training in Population and Family Planning	NIH[1/] -- National Institute of Child Health and Human Development HSA -- Bureau of Community Health Services ADAMHA -- National Institute of Mental Health CDC
Education Programs	
1. Sex and Family Life Education at Elementary and Secondary School and College Levels	OE ADAMHA -- National Institute of Mental Health
2. Professional Schools	
(a) Physicians, nurses, and other health professions	HRA -- Bureau of Health Resources Development HSA Bureau of Community Health Services
(b) Social workers	SRS -- Community Services Administration -- Office of Research and Demonstrations
(c) Teachers	OE
3. Curriculum Development for Above Programs	SRS -- Community Services Administration HRA -- Bureau of Health Resources Development OE ADAMHA -- National Institute of Mental Health

1/ National Institutes of Health

Table 2 (Cont'd)

Other DHEW Population and Family Planning
Activities by Function and DHEW Operating Agency

Function	DHEW Operating Agency with Funding and Program Responsibility
Research	
1. Reproductive Physiology and Contraceptive Development; evaluation of safety and possible adverse effects	NIH -- National Institute of Child Health and Human Development FDA[1/]
2. Social Research	SRS -- Community Services Administration -- Office of Research and Demonstrations HSA -- Bureau of Community Health Services ADAMHA -- National Institute of Mental Health HRA -- National Center for Health Statistics NIH -- National Institute of Child Health and Human Development
3. Administrative Research (a) Utilization studies (b) Demonstrations in innovative service delivery mechanisms (c) Evaluation methods	SRS -- Community Services Administration -- Medical Services Administration -- Assistance Payments Administration -- Office of Research and Demonstrations HSA -- Bureau of Community Health Services HRA -- National Center for Health Statistics -- Bureau of Health Services Research and Evaluation
4. Facilities Construction	HRA -- Bureau of Health Resources Development

1/ Food and Drug Administration

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Table 2 (Cont'd)

Other DHEW Population and Family Planning
Activities by Function and DHEW Operating Agency

Function	DHEW Operating Agency with Funding and Program Responsibility	
Evaluation		
1. Overall Evaluation and Coordination	OS[1/]	-- Office of the Assistant Secretary for Planning and Evaluation
	OASH[2/]	-- Office of Population Affairs
2. Medical Services Evaluation	HSA	-- Bureau of Community Health Services
	HRA	-- Bureau of Health Services Research and Evaluation
	ADAMHA	-- National Institute of Mental Health
3. Social Services Evaluation	SRS	-- Community Services Administration
		-- Medical Services Administration
		-- Office of Research and Demonstrations
	ADAMHA	-- National Institute of Mental Health

1/ Office of the Secretary
2/ Office of the Assistant Secretary for Health

II

OFFICE OF THE SECRETARY

Office of the Assistant Secretary for Planning and Evaluation

The Assistant Secretary for Planning and Evaluation has primary responsibility for the preparation of the five-year budget plan and the Department's program memoranda. This office is also responsible for the overall evaluation of the Department's programs.

The Office of the Deputy Assistant Secretary for Health Planning and Analysis works closely with the Office of Population Affairs in the development of appropriate planning documents, program memoranda, and evaluation studies.

Office of the Assistant Secretary for Human Development

In July 1969, the Office of Child Development (OCD) was established in the Office of the Secretary of HEW to serve as a point of coordination for Federal programs for children and their families and to act as a national advocate of services for children. On April 1, 1973, OCD became part of a new Office of Human Development at HEW which focuses on groups of Americans with special needs.

While the Office of Child Development does not directly operate any programs on family planning, Project Head Start and other OCD demonstration programs, such as Home Start and Child and Family Resource Programs, make social services available to parents. Social worker aides and health specialists in these programs are in contact with community agencies that conduct planned parenthood education and distribute information on family planning. Much of the material published and distributed by these agencies encourages parents to space their children and to talk to a physician or social worker about family planning.

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III

PUBLIC HEALTH SERVICE

Office of the Assistant Secretary for Health

The Office of Population Affairs (OPA) serves as a focal point for coordination of Department population research and family planning services activities. The Deputy Assistant Secretary for Population Affairs (DASPA) heads the OPA and has full line authority and responsibility for directing population research and family planning services within the health agencies. P.L. 91-572, the "Family Planning Services and Population Research Act of 1970," establishes the OPA by statute and delineates the functions of the Office as follows:

> The Secretary shall utilize the Deputy Assistant Secretary for Population Affairs--
>
> (1) to administer all Federal laws for which the Secretary has administrative responsibility and which provide for or authorize the making of grants or contracts related to population research and family planning programs;
>
> (2) to administer and be responsible for all population and family planning research carried on directly by the Department of Health, Education, and Welfare or supported by the Department through grants to, or contracts with, entities and individuals;
>
> (3) to act as a clearinghouse for information pertaining to domestic and international population research and family planning programs for use by all interested persons and public and private entitities;
>
> (4) to provide a liaison with the activities carried on by other agencies and instrumentalities of the Federal Government relating to population research and family planning;
>
> (5) to provide or support training for necessary manpower for domestic programs of population research and family planning programs of service and research; and
>
> (6) to coordinate and be responsible for the evaluation of the other Department of Health, Education, and Welfare programs related to population research and family planning and to make periodic recommendations to the Secretary.

In addition to its primary program direction activities, the OPA serves as a staff office for the Assistant Secretary for Health. This function involves advising the Secretary, through the Assistant Secretary, on policy and new legislation; participating in legislative and fiscal planning; and preparing reports on departmental and inter-departmental activities for the Secretary and the Congress. The OPA also prepares staff documents for the Secretary and for the White House.

Besides direct coordination of DHEW programs, the OPA works in close cooperation with, and provides leadership to, population research and family planning activities of other Federal agencies.

A continuing partnership between the Government and other concerned organizations is essential. The past work of private agencies in population-related fields has laid a foundation on which the official agencies continue to build. Therefore, the OPA maintains effective liaison with interested public and private organizations.

The OPA also maintains close communication with the population centers of major universities so that training can be geared to actual needs as they are revealed in ongoing DHEW programs.

In order to stimulate concerned professional and citizen groups to develop family planning resources, the OPA provides leadership at regional meetings, conferences or similar activities.

The Office of International Health (OIH), a staff office to the Assistant Secretary for Health, serves as the focal point within the Department for policy guidance and program coordination relating to international health. As such, it has overall responsiblity for the administration of the Scientific Activities Overseas (Special Foreign Currency Program) Appropriation.

The Special Foreign Currency appropriation is an important supplementary resource which enables the health agencies to support a broad range of health research and related activities in designated foreign countries. The countries designated by the Treasury Department as excess currency countries for Fiscal Year 1976 are the Arab Republic of Egypt, Burma, Guinea, India, Pakistan, Poland, and Tunisia.

All financial support under this appropriation is in the form of local currencies that have accrued to the United States either through the sale of surplus agricultural commodities under the terms of Public Law 83-480, the Agricultural Trade Development and Assistance Act of 1954, as amended, or through U.S. loan programs.

Population and family planning research has always been an important component of this PHS Program. There are presently 13 ongoing projects in five countries (Yugoslavia, Poland, India, Pakistan, and Egypt), representing a total obligated cost of $3,191,000 equivalent in local currencies. These projects include basic research on reproductive physiology, studies to evaluate the safety of fertility regulating methods currently in use, and demographic research.

Two noteworthy projects are going on now in Yugoslavia. These are studying the effects of hormonal contraceptives on cervical cytology. These studies, which were initiated in 1970, are the longest-term studies on this subject undertaken by the United States. They hold considerable promise for providing insight into the incidence of cervical cancer in a population of long-term users of these drugs.

Due to a number of problems which are neither related to the quality of the Program as a whole nor to the potential for productive research in the excess currency countries, no new population or family planning projects have been funded in Fiscal Year 1975. During Fiscal Year 1976, however, it is hoped that several new projects will be initiated. Efforts are being focused on developing projects

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directed toward improving mechanisms for the delivery of family planning services, development of new methods of fertility regulation, basic studies of reproductive processes, additional demographic research, and sociological studies to determine relationships between population size, growth, composition and distribution and the general welfare, measured from a variety of viewpoints.

Prospects for the implementation of such projects in India and Egypt are good. The Office is working with health officials of both countries under the aegis of the recently established U.S.-India and U.S.-Egypt Joint Cooperation Commissions to develop long-term programs of cooperation in several areas of mutual interest.

The Office also provides services to the Agency for International Development (AID) on population and family planning programming and facilitates coordination and exchange among concerned U.S. and international agencies. About 70 developing countries are reached by the Program through direct support or regional projects. Numerous U.S. institutions as well as international organizations are involved in its implementation through contracts and grants.

The OIH staff contributes mainly to those AID projects aimed at the development of more adequate systems for the delivery of clinical and educational services and the preparation of manpower. The services provided to AID include problem analysis, project design, identification of technical resources, review of project proposals, program evaluation, planning of training workshops and guidance on implementation problems. This entails field visits to the AID assisted countries; working with international organizations; participating in AID task forces, committees, and meetings; and, provision of information and resource materials as requested by AID Missions, AID contractors and individuals concerned.

Food and Drug Administration

Programs of the Food and Drug Administration (FDA) of DHEW are authorized by the Food, Drug and Cosmetic Act of 1938, as amended. The FDA approves contraceptive drugs for safety and effectiveness before they are marketed and maintains surveillance over both contraceptive drugs and "non-drug" contraceptive devices (those which do not incorporate releasable metals or drugs) after they are marketed. While FDA does not currently have preclearance authority for non-drug contraceptive devices, pending legislation would permit the FDA to exercise more control over certain contraceptive devices through requiring scientific review prior to marketing or through establishing standards for such devices. FDA involvement in population research and family planning services lies primarily in:

(1) Sponsoring or monitoring the progress of research necessary to carry out its regulatory responsibilities relating to oral contraceptive safety.

(2) Using its regulatory functions with regard to the safety and effectiveness of contraceptive drugs and devices.

(3) Maintaining a reporting system which serves as a clearinghouse for information concerning adverse reactions associated with contraceptives.

The first oral contraceptive agents were approved by the FDA for general use in 1961. By 1974, there were over 45 such agents on the market. Several new drug applications are currently under review, including a three-month injectable contraceptive and a postcoital contraceptive.

Having published its "Second Report on the Oral Contraceptives" in August 1969, the FDA Advisory Committee on Obstetrics and Gynecology continues to assist in activities related to family planning. This Committee has participated in revising oral contraceptive labeling, in updating guidelines for clinical investigations of oral contraceptives, and in evaluating the influence of estrogen content in the thromboembolic action of oral contraceptives. The Committee has also deliberated upon the problem of the tumorigenic action of certain steroidal contraceptives and has assessed the safety and efficacy of certain systemically administered contraceptives and of intrauterine devices (IUDs) incorporating releasable metal or a hormone.

FDA provides expert advice to the pharmaceutical industry and the academic community in the conduct of studies to obtain data concerning the safety and efficacy of contraceptive drugs. In addition, FDA solicits the views of consumers and other interested parties on proposed consumer information materials to accompany the contraceptive market package.

In order to develop adequate information to assure the safety and effectiveness of contraceptive drugs and devices, the FDA has initiated several research projects. The FDA is supporting an investigation of the carcinogenic and diabetogenic potential of certain oral contraceptive steroids in long-range studies in Rhesus monkeys and beagle dogs at the International Research and Development Corporation in Mattawan, Michigan. These studies follow the protocol prescribed by FDA to the pharmaceutical manufacturers in 1967, and under which already marketed as well as investigational compounds are currently being evaluated. Since initiation of the studies, three investigational products have been found to induce mammary tumors in beagle dogs. Two marketed formulations containing tumorigenic progestins have been withdrawn by the manufacturers. The long-

range design of the investigations is intended to provide some indication of the possible carcinogenic hazard to long-term human users of the contraceptives. The FDA is also gathering information regarding the possible association between liver tumors and oral contraceptive use.

Utilizing funds from the PL-480 program in Yugoslavia, the FDA has developed four studies relating to oral contraceptive safety. A two-year study of 200 women at the Institute for Mother and Child Welfare in Zagreb, Yugoslavia, was conducted to assess the effect of selected oral contraceptives on carbohydrate and lipid metabolism. The final report from this research is expected early in 1975.

A second FDA study under PL-480 support has been initiated at the University Teaching Hospital for Obstetrics and Gynecology in Ljubljana, Yugoslavia. This study has two objectives: (1) To determine in a small study (offspring of 200 women) whether congenital abnormalities or abnormal karyotypes develop in the offspring of women using oral contraceptives within three months of conception. (2) To determine in a large study (over 28,000 women have been entered) whether oral contraceptives increase the risk of cervical cancer. A final report on the outcome of pregnancy study will be available during 1975. The cervical cancer study is ongoing, with data collection annually. Over 23,000 woman years of exposure were logged in both the test group and control group up to December 31, 1973. Although PL-480 funds will not be available for the cervical cancer study after December 31, 1974, the FDA hopes to utilize Bureau of Drugs research funds to extend data gathering for one additional year or until December 31, 1975.

A third FDA PL-480 project at the Institute of Hygiene and Social Medicine in Sarajevo, Yugoslavia, is expected to continue until 1979. This study also has two objectives: (1) To compare the changes in cervical cytology in 6,000 oral contraceptive users with those in a similar group of women using other family planning methods. (2) To study all women (7,600) delivering in three population centers to ascertain the possible relationship between abnormal pregnancies and malformed infants and the use of drugs, hormones, and exposure to environmental hazards.

A fourth FDA PL-480 study in Belgrade, Yugoslavia, is scheduled for completion in December 1974. This three-year study is aimed at investigating the effect of oral contraceptive use on coagulation mechanisms.

Recognizing that prostaglandins may have significant potential in family planning, the FDA is monitoring ongoing prostaglandin research and has developed protocols for pharmacological and clinical investigation of these products. During 1973, the FDA approved the use of prostaglandin as a second trimester abortifacient. In addition, studies are being conducted to evaluate the use of prostaglandins in inducing labor at term.

Proposed revisions to the oral contraceptive labeling directed to physicians were presented by the FDA to its Obstetrics and Gynecology Advisory Committee on November 29, 1973, for evaluation. When finalized, the revised labeling will be put into use.

In the June 5, 1971, Federal Register, the FDA Commissioner published a proposal to make intrauterine implants which incorporate heavy metals, drugs, or other added substances, "new" drugs. Thus, a "Notice of Claimed Investigational Exemption for a New Drug" must be submitted to the FDA to cover clinical investigations of the safety and efficacy of such contraceptives. In addition, an approved New Drug Application is required for marketing such implants.

Although the FDA does not currently have pre-marketing control over "non-drug" medical devices, it maintains surveillance over such devices after they are marketed to ensure their safety and efficacy. As previously noted, pending legislation would permit the FDA to exercise more control over certain contraceptive devices through mandating pre-marketing scientific review or through setting standards for such devices. The FDA Panel on Review of Obstetrical and Gynecological Devices has classified all Obstetric and Gynecologic devices into three proposed regulatory categories: (1) Devices which should be subject to pre-market review, (2) Devices for which standards should be set and enforced to assure safety and reliability, and (3) Devices which should be exempt from standard setting and pre-market review but subject to certain general controls. The Panel will recommend criteria for scientific investigations of those devices that have been placed in standards and scientific review categories.

In June 1974, when the safety of the Dalkon Shield IUD was brought into question, the FDA set up an ad hoc Obstetrics and Gynecology Advisory Committee to evaluate the available data and make recommendations to the FDA Commissioner on the safety and efficacy of IUD's in general and the Dalkon Shield in particular. Following an August 1974 public hearing on the Dalkon Shield and other IUD's, the Committee assigned a special subcommittee to review data pertinent to the Dalkon Shield and concluded, "IUD's have been shown by extensive use and studies to be a safe and reliable means of contraception and they compare favorably with the standard in this field---namely, oral contraceptives." Having reviewed the subcommittee's report, the Committee met in October 1974 and made recommendations concerning the Dalkon Shield, professional and patient IUD labeling, and proposed IUD studies. In December 1974, the FDA announced that it would permit sales of a modified version of the Dalkon Shield under a carefully controlled program involving stringent monitoring of patients for adverse effects. The modified Shield would have a monofilament tail rather than the current multifilament tail in order to reduce the possibility of the multifilament tail acting as a wick to draw harmful bacterial into the uterus. In addition, the Shield would be distributed only to physicians who agreed to register new patients with the manufacturer and keep detailed records of their experiences with the device.

While there is an abundance of scientific literature and research on inert and drug IUD's, it is largely uncoordinated and of limited practical value to those who insert IUD's. Therefore, the FDA has contracted with the Battelle Northwest Research Institute to assist in updating and making available by 1975, the 1968 FDA "Report on Intrauterine Contraceptive Devices." Based on a comprehensive review and analysis of the scientific and clinical data, the updated report will represent an attempt to: (1) Identify clinical studies in which there is valid evidence of the effectiveness of both inert and drug IUD's, (2) Identify any hazards associated with inert and drug IUD's. (3) Identify any physiological and histochemical effects produced by IUD's other than contraceptive effects, (4) Identify the mode of action by which the contraceptive effects are produced, (5) Identify criteria and procedures for use in the selection and insertion of IUD's, and (6) Identify the nature of the information which should be made available to physicians and patients. In addition to the Battelle report, the FDA is considering joint funding of IUD safety and efficacy studies with the NICHD.

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Health Services Administration

The Health Services Administration (HSA) is the major administrative support agency for Federal programs of subsidized family planning services. In the HSA, family planning services are provided by the Bureau of Community Health Services (BCHS), the Indian Health Service (IHS), and the Bureau of Medical Services (BMS). The BCHS administers programs formerly administered by the National Center for Family Planning Services, the Maternal and Child Health Service, and the Community Health Service.

Review and approval of services project grant applications is carried out in the DHEW Regional Offices. Regional Family Planning Program Consultants serve as coordinators for family planning within the Regional Offices.

The Bureau of Community Health Services administers programs under the "Family Planning Services and Population Research Act of 1970" (PL 91-572), which established Title X of the Public Health Service Act[1/]; and Title V of the Social Security Act as amended by the "Child Health Act of 1967" (PL 90-248) and the "Public Debt Limitation Act of 1973" (PL 93-53).

Title X of the Public Health Service (PHS) Act authorizes project grants to family planning services providers, grants and contracts for training family planning services personnel, grants and contracts for services delivery improvement research, and grants and contracts for the development and distribution of family planning information. Categorical project grants under PHS Act Title X represent the major Federal source of direct funding for family planning services.

Title V of the Social Security Act (SSA) authorizes maternal and child health formula grants to assist States in extending and improving their services for promoting the health of mothers and children, especially in rural areas. PL 90-248 specifies that not less than six percent of the annual appropriations under SSA Title V must be available for family planning services.

The broad purposes of the program, set forth in PL 91-572 include:

1. To assist in making comprehensive voluntary family planning services readily available to all persons desiring such services;

2. To improve administrative and operational supervision of family planning services;

3. To enable public and non-profit private entities to plan and develop comprehensive programs for family planning services;

4. To develop and make readily available information (including information materials) on family planning to all persons desiring such information;

5. To evaluate and improve the effectiveness of family planning service programs; and

6. To assist in providing trained manpower needed to effectively carry out family planning programs.

1/ Funding authorization under Public Health Service Act Title X expired June 30, 1974. The program is currently operating under a continuing resolution.

Public Health Service Act Title X

Title X of the PHS Act authorizes funds for family planning service projects, training grants and contracts, information and education activities, and services delivery improvement research.

Project Grants

The family planning project grant program of BCHS has grown from 80 grants and $12 million in obligations during fiscal year 1969 to an estimated 282 grants and $94.5 million in obligations during fiscal year 1975. The 282 grantees currently support services at 3,600 sites. With a service delivery capacity of approximately 1,600,000 persons, these projects provide a range of services which include comprehensive family planning medical, educational, and social services (including health screening tests for cancer, anemia and venereal disease).

Several fiscal year 1975 program initiatives are designed to improve project management and quality of care. Program indicators (performance standards) are being introduced in order to monitor and upgrade, where necessary, the quality of medical services and the efficiency of project operations.

In order to facilitate project monitoring, new reporting requirements are being added to the national reporting system. Continuing efforts are also being made to increase the collection of available third-party reimbursements, particularly those authorized under Titles IV-A and XIX of the Social Security Act.

In fiscal year 1976, the quality of services provided will also be addressed by the introduction of ambulatory health care standards for family planning programs. The improved system will provide the program with better information.

Training

In fiscal year 1975, 19 training grants and contracts will be awarded to provide for the development of management skills for key personnel; the training of service delivery staff; and the development of training guides, audiovisual aids, self-instructional courses, and related materials. Approximately 5,600 personnel involved in the delivery of family planning services will receive training. These include physicians, nurses, health educators, administrators, and office and clinic personnel.

Information and Education

Current information and education activities supported under PHS Act Title X focus upon informing the general public of the benefits to be derived from comprehensive family planning services and supporting special education programs and activities for high-risk and hard-to-reach populations. A major objective is to provide direct support to service projects in developing comprehensive patient education programs.

Under a national multi-media campaign being launched in fiscal year 1975, general information materials are being developed for males, teenagers, young married couples who wish to space their children, and older couples who feel their families are complete. Culturally sensitive materials are being developed for the Spanish speaking and for American Indians. State leaders and parents are receiving assistance in the development of strategies for establishing family planning

and family life educational programs for the mentally retarded to be carried out by the States.

A model education program is being implemented in a school system to inform junior high students concerning the prevention of unwanted conception and venereal disease (Project Teen Concern).

During fiscal year 1976, activities designed to reach high-risk and hard-to-reach populations will continue to receive high priority. A model for the effective delivery of family planning educational services will be developed to meet the special needs of the retarded. Studies of the impact of informed consent education on methods choice, continuation in the program, and subsequent fertility will be conducted. The Project Teen Concern model will be extended to other areas throughout the country.

Services Delivery Improvement

The objective of services delivery improvement research is to develop more effective and efficient methods and techniques for the delivery of family planning services. Special studies and programs are carried out to support the continued development and improvement of a national family planning program responsive to patient needs, to family planning priorities, to significant Regional, State, and local variations, and to special population groups.

In fiscal year 1975, contracts will be awarded to expand the DHEW Region I (Boston) data system to include an automated billing system to assist in obtaining third-party reimbursements; to implement the family planning evaluation model in all projects; and to conduct a clinic operations study to enable managers to make optimum utilization of clinic time and manpower. Other special studies include projects to test techniques for providing family planning services to the handicapped and to demonstrate the effective utilization of the physician extender in family planning clinics. A special training curriculum for teaching natural family planning methods is also being developed to improve the capability of Federally-funded family planning clinics to serve patients who prefer natural methods of family planning.

In fiscal year 1976, service delivery improvement activity will focus on developing new and improved techniques and methods to assist family planning programs to increase productivity and to provide services more effectively. The DHEW Region I (Boston) automated billing system will be tested in four additional States. Over one-third of the family planning projects will receive assistance in improving their accounting systems in order to increase their ability to obtain third-party reimbursements. Demonstration projects such as specialized information, referral, and counselling techniques in rural areas will be tested to increase the effectiveness of delivering family planning services to the hard-to-reach, the disabled, and the dropout. Other activities will include the development of clinic management tools, including self-instruction staff materials, to assist family planning managers in improving clinic operations.

Social Security Act Title V

Under Maternal and Child Health formula grants, States are assisted in extending and improving their services for the promotion of the health of mothers and children, especially in rural areas. The States have broad discretion in the use of these funds, but the Maternal and Child Health's health service programs are generally preventive in orientation. The Crippled Children's programs provide diagnostic and treatment services.

Effective June 30, 1974, Social Security Act Title V project grants were folded into formula grants, as provided by law. Under Maternal and Child Health formula grants, States provide family planning services as a part of their programs of projects requirement to develop programs in each of five categories, including family planning.

As a condition of State plan approval, the plan for Maternal and Child Health services must provide for the development of demonstration projects with special attention to family planning services for mothers in low-income areas and among groups in special need. Acceptance of family planning services must be voluntary and must not be a prerequisite of eligibility for the receipt of services under the plan. The 1967 Amendments to the Social Security Act further require a State to make a satisfactory showing that it is extending the provision of services under its plan, including family planning services, with a view to making such services available to all parts of the State by July 1, 1975.

Table 3, based on reports submitted by the States, shows the number of women receiving family planning services through State programs supported in part by Maternal and Child Health Formula Grants. Table 4 shows the number served in Maternity and Infant Care Projects for fiscal years 1971 through 1974. The States reported that SSA Title V Maternal and Child Health Formula Grants helped support family planning services for 1,553,749 individuals during fiscal year 1974, while the Maternity and Infant Care Projects served 104,657.

Nurse training programs conducted under Maternal and Child Health activities included family planning components. BCHS supports long-and short-term training programs for a variety of health professionals in the form of grants and technical consultation. All graduate nursing programs receiving support offer theoretical content and clinical practice in family planning.

Nurse-midwifery programs have a major family planning component integrated into both their classroom work and their clinical practice. The following table identifies these programs:

	Program Length	Number of Students Supported by MCH	Degree
University of Mississippi	12 months	20	Certificate
Columbia University	12 months	16	M.S.
Johns Hopkins University	24 months	14	M.P.H.
University of Utah	24 months	18	M.S.
State University of New York	5 months (internship)	12	None
University of Illinois	24 months	6	M.S.

The following examples illustrate the types of activities conducted by some of these programs:

At Columbia University, nurse-midwifery students are given experience in inserting and removing IUDs, fitting diaphragms, dispensing oral contraceptives, and in providing individual and group counseling. Because this group of nurse-midwifery

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TABLE 3

Number of Women Provided Family Planning Services Under State Programs of Maternal and Child Health, Fiscal Years 1974, 1973, 1972 and 1971

	1974 Provisional	1973	1972	1971
Total	1,553,749	1,107,721#	1,052,643[1]	763,234
Region I	76,853	15,918	12,000[2]	3,900
Connecticut	---	---	---	---
Maine	1,300***	1,300**	12,000	3,900
Massachusetts	---	---	--- [2]	---
New Hampshire	---	---	---	---
Rhode Island	75,553	14,618	---	---
Vermont	---	---	---	---
Region II	0	0	10,010[3]	10,034
New Jersey	---	---	---	---
New York	---	---	9,646[3]	10,034
Puerto Rico	---	---	364	---
Virgin Islands	---	---	---	---
Region III	192,730	163,761	66,075[4]	68,516
Delaware	9,223***	9,223	7,440	5,676
Dist. of Columbia	---	---	---	---
Maryland	44,783***	44,783	8,693[4]	4,816
Pennsylvania	8,434	6,332	---	---
Virginia	114,065[1]	90,000*	39,946[5]	51,528
West Virginia	16,225	13,423	9,996	6,496
Region IV	534,206	444,726	507,988	341,004
Alabama	43,173	21,227	62,528	50,669
Florida	107,793	104,348	98,077	67,704
Georgia	84,250	98,307	88,628	75,799
Kentucky	26,133	28,401	49,168	17,170
Mississippi	37,400	32,711	30,156	22,095
North Carolina	82,292	55,089	48,644	35,081
South Carolina	55,975	38,399	32,554	---
Tennessee	97,190	66,244	98,233	72,486
Region V	301,233	89,244	116,059[6]	85,022
Illinois	5,610[7]	3,700*	6,623[5/6]	5,997
Indiana	16,446	12,754	10,525	5,127
Michigan	130,204[7]	28,770	20,374[7]	9,654
Minnesota	3,170	3,170	---	1,300
Ohio	141,809[12]	38,059[12]	76,904[8]	62,944
Wisconsin	3,994	2,791	1,633	---
Region VI	106,790	103,797	102,059	68,102
Arkansas	23,783***	23,783	19,114	15,066
Louisiana	---	---	---	---
New Mexico	7,653	4,660	---	3,260
Oklahoma	---	---	35,850[9]	17,645
Texas	75,354***	75,354	47,095	32,131
Region VII	69,221	68,120	41,609	33,466
Iowa	2,177***	2,177	---	---
Kansas	25,283	24,182	---	8,300
Missouri	41,630***	41,630	41,421	25,166
Nebraska	131***	131	188	---
Region VIII	15,429	15,317	10,338	4,962
Colorado	7,321***	7,321	4,761	1,242
Montana	---	---	---	1,893
North Dakota	1,583***	1,583[3]	---	549
South Dakota	1,196***	1,196	1,093	---
Utah	4,523***	4,523	4,219	963
Wyoming	806	694	265	315
Region IX	222,395	168,686	150,060	108,461
American Samoa	---	---	---	---
Arizona	40,184	25,369	25,629	11,804
California	177,720	138,826	121,074[10]	93,931
Guam	---	---	---	---
Hawaii	607***	607	390	---
Nevada	3,884***	3,884	2,967	2,726
Trust Territorica	---	---	---	---
Region X	34,982	38,152	36,445	39,767
Alaska	---	---	---	892
Idaho	2,418	2,757	1,746	920
Oregon	32,474	35,305	28,979	6,275
Washington	90***	90	5,720[11]	31,680

Footnotes Table 3

*Estimated from Visits
**Estimated from Expenditure Data
***1973 Data
#National and Regional Totals Include Estimates for Non-Reporting States.
1/Includes Chicago, Ill., 36 Local Health Departments in Massachusetts, New York City, N.Y., and Baltimore, Md.
2/Excludes Data from 36 Local Health Departments.
3/Excludes New York City.
4/Excludes Baltimore City, Md.
5/Estimated.
6/Excludes Chicago Board of Health.
7/Estimated from Report or New Patient and Return Visits.
8/Data not Available from 10 Local Health Departments.
9/Data not Available from two Counties.
10/Incomplete Reporting.
11/Data not Available for 4 Local Health Departments.
12/Data for Year Ending Dec. 31.

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TABLE 4

Number of Women Provided Family Planning Services in Maternity and Infant Care Projects Fiscal Years 1974, 1973, 1972 and 1971

Total - U. S. Region and State	1974 Provisional	1973	1972	1971
TOTAL	104,657	118,315	124,892	134,685
Region I	1,913	3,575	5,643	4,941
Connecticut	777	852	1,091	1,150
Maine	233	143	6	-
Massachusetts	149	1,726	3,855	3,328
New Hampshire	-	-	-	-
Rhode Island	754*	754	691	463
Vermont	-	-	-	-
Region II	17,577	18,804	20,201	21,957
New Jersey	1,089	1,089	449	622
New York	14,895	16,151	18,094	19,143
Puerto Rico	1,593	1,564	1,658	2,192
Virgin Islands	-	-	-	-
Region III	14,709	15,145	16,960	19,553
Delaware	-	-	-	-
Dist. of Columbia	7,650	7,597	7,855	5,615
Maryland	1,237	1,322	2,076	6,939
Pennsylvania	3,315*	3,596	4,386	4,218
Virginia	1,009	1,093	1,090	1,245
West Virginia	1,498	1,537	1,553	1,536
Region IV	36,106	43,990	42,198	35,244
Alabama	5,472	4,900	4,497	2,998
Florida	16,013	16,084	15,637	12,580
Georgia	9,368	17,505	16,405	14,631
Kentucky	439	431	558	552
Mississippi	868	932	849	815
North Carolina	1,460	1,434	1,380	1,185
South Carolina	2,486	2,704	2,872	2,483
Tennessee	-	-	-	-
Region V	10,943	12,592	15,189	28,532
Illinois	4,699	3,883	6,173	18,474
Indiana	111	141	13	-
Michigan	1,019	3,299	3,028	2,858
Minnesota	960	850	827	1,747
Ohio	4,154	4,419	5,148	5,453
Wisconsin	-	-	-	-
Region VI	13,716	15,117	12,812	13,603
Arkansas	1,125	1,345	2,233	2,316
Louisiana	-	-	-	-
New Mexico	1,783	1,499	1,048	920
Oklahoma	-	-	-	-
Texas	10,808	12,273	9,531	10,367
Region VII	1,300	2,470	4,147	3,767
Iowa	-	-	-	-
Kansas	-	-	-	-
Missouri	624	1,838	2,555	2,412
Nebraska	676	632	1,592	1,355
Region VIII	6,959	4,817	4,858	4,713
Colorado	6,959	4,817	4,858	4,713
Montana	-	-	-	-
North Dakota	-	-	-	-
South Dakota	-	-	-	-
Utah	-	-	-	-
Wyoming	-	-	-	-
Region IX	498	884	750	679
American Samoa	-	-	-	-
Arizona	-	-	-	-
California	163	376	249	252
Guam	-	-	-	-
Hawaii	320	484	501	427
Nevada	15	20	-	-
Trust Territories	-	-	-	-
Region X	936	921	2,134	1,696
Alaska	-	-	-	-
Idaho	274	199	146	157
Oregon	364	348	462	338

students manages a maternity clinic for adolescents, they have an additional opportunity to initiate family planning with young people.

Some nurse-midwifery students at the State University of New York gave high priority to family planning and elected a block experience in the Family Planning Service of Kings County Hospital of Downstate Medical Center. Interns in the program felt that family planning comprised an important aspect of comprehensive maternity care. Most job requirements include responsibility for this area of care.

Maternal and Child Health supported University Affiliated Facilities, which offer multi-disciplinary training in the provision of services to the mentally retarded, provide training to meet the special family planning needs of the retarded. The primary emphasis is on teaching them responsibility for their sexual activity. The Institute for the Study of Mental Retardation and Related Disabilities at the University of Michigan, the Eunice Kennedy Shriver Center for Mental Retardation at the Walter E. Fernald State School in Waltham, Massachusetts, and the John F. Kennedy Child Development Center at the University of Colorado are among those University Affiliated Facilities which offer their social work and nursing students background on the rights of retarded adults, as well as specific knowledge of physiology, venereal disease, and contraceptives which can be used to counsel retarded individuals.

Related Family Planning Activities in the Bureau of Community Health Services

While the remaining BCHS programs do not have a primary focus on family planning, they encourage the integration of family planning activities within the range of health services which they offer.

Currently 157 Community Health Centers (authorized under PHS Act Title III, Section 314(e))[1/] foster the delivery of family-oriented health services, including family planning, to approximately 1,425,000 people. These centers are generally located in areas with a high concentration of urban and rural poor, areas where many persons desiring family planning services are likely to reside.

Health Maintenance Organizations (authorized under PHS Act Title XIII) provide comprehensive health services on a prepaid capitation basis. Family planning is an integral part of this activity.

Migrant and seasonal farmworkers and their families are provided access to health care services at 355 service sites which are supported through 96 migrant health grants (authorized under PHS Act Title III, Section 310).[1/] Some of these sites include family planning among the range of services provided.

The National Health Service Corps (authorized under PHS Act Title III, Section 329) currently has 405 health professionals assigned in 193 communities which were previously "critically short" of health manpower. Family planning services are among the services provided to persons residing in these communities.

Formula Grants to States for Public Health Services (authorized under PHS Act Title III, Section 314(d))[1/] assist the States in establishing and maintaining adequate public health services in accord with State-established priorities. Many States have used the flexibility of these grants to support family planning services.

1/ Funding authorizations under PHS Act Title III, Sections 310, 314(d), and 314(e) expired June 30, 1974. Programs authorized under these Sections are currently operating under a continuing resolution.

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The Indian Health Service of the Health Services Administration provides comprehensive health services, including family planning, to American Indians and Alaskan natives under PL 83-568. The Indian Health Service has been active in the field of family planning since fiscal year 1965. From that time through June 30, 1974, family planning services have been provided to an estimated 59,900 women. In fiscal year 1974, there were 44,700 medical visits by 24,700 Indian and Alaskan native women for family planning services. In fiscal year 1974, the number of Indian women 15-44 years of age was estimated at 98,000.

The Bureau of Medical Services (formerly the Federal Health Programs Service) of the Health Services Administration is responsible for direct health services to certain Federal beneficiaries. The basic Public Health Service Act, (PL 410, 78th Congress, 58 Stat. 683, 1944), and as amended, particularly Sections 321-346 and the Dependents Medical Care Act and its amendments (PL 84-569) provide beneficiaries with comprehensive inpatient and outpatient medical services. Family planning services are included in these programs. Family planning information and counselling is provided to Federal employees through the Federal Employee Health Program authorized by PL 79-658.

The Bureau of Medical Services provides comprehensive family planning services to eligible beneficiaries through its system of hospitals and outpatient clinics. Family planning services may include the prescription and provision of pharmaceutical preparations including oral contraceptives and mechanical devices, surgical sterilization, and counselling.

All postpartum patients are offered family planning information and services as part of the follow-up medical care at the Public Health Service Hospital in New Orleans which has the only obstetrical service within the Bureau of Medical Services. All U. S. Public Health Service hospitals and outpatient clinics provide family planning services upon request. There were an estimated 18,400 visits in fiscal year 1972, 12,200 visits in fiscal year 1973, and 10,000 visits in fiscal year 1974. Community oriented family planning services are provided at the Boston Public Health Service Hospital through an agreement with the Massachusetts State Department of Health. The Staten Island Public Health Service Hospital provides laboratory and radiology services to the Family Planning and Health Clinic of the Staten Island Community Corporation. The number of family planning visits declined in fiscal year 1974 becaused reduced staffing required a cutback in discretionary services and because of the termination of obstetrical services at the Staten Island Public Health Service Hospital.

The Division of Federal Employee Health, through the health unit operations, provides the following family planning education and counselling services upon request:

1. Family planning literature
2. Access to a physician and/or nurse to discuss family planning
3. Referral to public and private health care facilities for family planning services

Health Resources Administration

The National Center for Health Statistics (NCHS) derives its authority in population from the general data collection and research provisions of Sections 304 and 306 of the Public Health Service Act, and from the transfer of certain functions relating to vital statistics from the Census Bureau to the Public Health Service. NCHS is responsible for collecting and analyzing the wide range of health and demographic statistics needed for health planning and program evaluation.

The NCHS collects and publishes natality, marriage and divorce, and mortality statistics. It also engages in research on the dynamics of population change and examines some of the social and economic factors associated with change. NCHS conducts annual vital records surveys. NCHS has just completed the first phase of a continuing survey of family growth in the United States. This survey is designed to collect data on factors affecting the birth rate, family planning, and infant and maternal health. It was conducted through the use of the field operations of a private survey organization with periodic interviewing of a representative sample of ever-married women in childbearing ages. Data from the survey will be released early in 1976.

NCHS and the Research Triangle Institute in North Carolina have collaborated in the development of a computer model intended to simulate the dynamics of population growth. A manual has been prepared and disseminated to enable others, within this country and abroad, to apply the model to their own population structure and problems.

NCHS is responsible for operating a uniform national family planning services reporting system. This reporting system was developed in two stages. NCHS worked with governmental and private family planning groups to initiate a provisional family planning reporting system. This provisional system provided data on the utilization of family planning services which were financed at least in part by Federal funds, and for which there was an immediate program need for data.

Based on the experience gained from operating the provisional system, NCHS developed the National Reporting System for Family Planning Services (NRSFPS) for use by all Federally-supported family planning programs, clinics, and service points, and by other agencies wishing to participate in the reporting system. The NRSFPS currently provides monthly, quarterly, and annual reports essential for the efficient and effective development, operation, and evaluation of family planning programs throughout the Nation.

A second NCHS program for providing information on family planning services (The National Inventory of Family Planning Services) was initiated in 1974. The National Inventory is a comprehensive listing of all sites in the United States that provide family planning services, whether these services are medical or non-medical. Annual censuses of the Inventory provide basic data on each facility, including information on staffing and services offered. The Inventory is also expected to provide the base for special sample studies from which additional, more detailed information can be acquired.

The Bureau of Health Resources Development develops, supports and evaluates State and areawide health planning programs that work to improve the health status of their respective populations. These programs consider the whole range of health concerns including family planning.

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Center for Disease Control

The Center for Disease Control (CDC) provides training to Epidemiologic Intelligence Service (EIS) officers. Some individuals in the program are being trained in an epidemiologic approach to evaluating family planning and population programs. The Family Planning Evaluation Division, CDC, provides assistance to State, local, and international health agencies in the evaluation of family planning programs. EIS officers and Public Health Advisors (PHA) are assigned in Georgia, New York, Tennessee, and California to develop and maintain data processing systems for family planning service statistics, to analyze contraceptive use and effectiveness, and to conduct special studies based on these analyses. In addition to these continuing assignments, short term assistance is given to family planning programs for improving program management, designing service statistics systems, and evaluating family planning program performance.

As State abortion laws became less restrictive in 1967, data concerning abortion mortality and the practice of legal abortion became increasingly important. CDC maintains surveillance of abortion practice and abortion deaths through a nationwide reporting system. In 1969 approximately 22,000 legal induced abortions were reported to CDC on a voluntary basis by State and local health departments. The following year more than 180,000 abortions were reported; in 1972 that number increased to 586,760; in 1973 the number increased to 615,831. Since 1972, New York City, Dallas, Philadelphia, Buffalo, Chicago, Portland (Oregon), and the States of New York, Arkansas, and Kansas have been assisted in assessing abortion-related health problems and in determining the measures necessary to prevent them. From the mid-1950's through the mid-1960's, abortion mortality did not decline even though other causes of maternal death decreased substantially. Since then, abortion mortality has continued to decrease. In 1969, 132 abortion-related deaths were reported. In 1970 there were 140 such deaths and, in 1971, 120 occurred. A marked decrease occurred in 1972 when 79 deaths were reported, and data for 1973 indicated a further decline to 47 abortion-related deaths. Data indicate that the risk of mortality increases with the length of gestation. CDC is undertaking a study to determine why women who decide on abortion delay that decision. Federal and State cooperation is necessary if the favorable trend in abortion mortality is to continue.

Epidemiologic field investigations of the medical consequences of drugs, devices, and techniques employed in family planning programs are being conducted. Morbidity and mortality associated with the use of the intrauterine device (IUD) was one of the studies conducted. Questionnaires were sent to physicians considered most likely to have inserted IUDs or to have examined women with IUD complications. More than 3,900 hospitalizations and five deaths occurred during the first six months of 1973. DHEW has assigned CDC the task of monitoring Federally-funded sterilizations on minors and those incapable of providing legal consent. Implementation of the Sterilization Surveillance Project is pending finalization of regulations.

Alcohol, Drug Abuse, and Mental Health Administration

The National Institute of Mental Health (NIMH) is authorized to serve as the principal focus for research and training in the behavioral and basic sciences related to the causes, diagnosis, treatment, and prevention of disorders in the biological and psycho-social factors that determine human behavior and development. Under this broad mandate many activities related to family planning are supported.

The National Institute of Mental Health recognizes the special contribution that can be made by mental health personnel in the area of family planning. The Institute is involved in this area of concern through its research, training, and service programs.

The Institute views family structure as it relates to the larger social structure and to such social structure variables as occupation, social class, economic status, and life style. Since the Institute recognizes that programs of family planning must be modified to fit the facts of a diverse society, it seeks to determine these facts as they relate to mental health issues.

The Institute is interested in the implications of family size for the physical and mental health of family members. It is also interested in child spacing and its effect on family functioning and on the personality development of children. It seeks to determine the strengths and weaknesses of differing family forms and sizes; the effects of abortion and sterilization; the role of adoption; and the implications of working mothers, increased family incomes, and day-care centers on the family planning process.

Thus, the Institute seeks to determine the kinds of mental health services needed by families of differing sizes and forms, the adequacy of one-parent homes in providing crisis support to individual members, and the correlations between family size and the emotional characteristics of family members. Biometric data, for example, indicate that the heads of families with one child - both parents present - have lower admission rates to psychiatric facilities than the heads of those families which contain several children; yet, the children of one-child families - both parents present - have higher rates of hospitalization than children in families where siblings are present. Data of this nature have important implications for the Institute's contribution to family planning services.

The Institute encourages and supports family planning services provided through community mental health facilities. In its training and educational support programs, NIMH stimulates family planning programs in the training of public health nurses, teachers, social workers, and others involved in sex and health education. Through the Center for Studies of Child and Family Mental Health, the Institute encourages research in mental health and the behavioral aspects of family life.

Examples of research grant projects which bear indirectly on family planning are communication and decision-making within families; patterns of family life; motivation; sex education; and population characteristics. The Center for Studies of Child and Family Mental Health investigates the structure of the American family; i.e., what factors contribute to breakdown in the family structure in the affluent suburban household; problems of role identification as a father for the third generation AFDC recipients. The NIMH Division of Intramural Research carries out projects on family formation, child spacing, and animal studies of population density.

National Institutes of Health

The research programs of the Department in the population sciences are directed by the National Institute of Child Health and Human Development. Section 444 of the Public Health Service Act authorizes the Institute to conduct and support research and training relating to maternal health, child health, and human development, including research and research training in the special health problems and requirements of mothers and children and in the basic sciences relating to the processes of human growth and development, including prenatal development.

Section 1004 of Public Law 91-572, "The Family Planning Services and Population Research Act of 1970," authorizes the Secretary of Health, Education, and Welfare to make grants and to enter into contracts "...to promote research in the biomedical, contraceptive development, behavioral, and program implementation fields related to family planning and population..." Expenditures by the Institute in fiscal year 1974 for population research were $51.0 million. They are projected to be $51.0 million for fiscal year 1975.

Other components of the National Institutes of Health provided $7.3 million in fiscal year 1974 to support a variety of extramural activities with important implications for population research. Research in reproductive endocrinology supported by the National Institute of Arthritis and Metabolic Diseases totalled approximately $2.8 million in fiscal year 1974. These studies provide basic information essential in the development of new methods for controlling reproductive processes. The National Cancer Institute's interests in reproductive endocrinology, other reproductive processes, and carcinogenic effects of synthetic estrogens are relevant to understanding normal function and fertility control. In fiscal year 1974, $1.7 million was spent to support these studies.

The National Heart and Lung Institute awarded $0.4 million for studies of the effects of estrogens, progestogens, and steroid contraceptives on blood clotting mechanisms and the physiology of circulation. Several studies in reproductive neuroendocrinology and genetic aspects of reproduction were supported by the National Institute of Neurological Diseases and Stroke and the National Institute of General Medical Sciences, respectively. Support for population research in these two Institutes totalled about $0.2 million in fiscal year 1974. The Division of Research Resources administers approximately $2.3 million in general research support relevant to the population field.

The National Institute of Child Health and Human Development (NICHD) and its Center for Population Research (CPR) have primary responsibility for the Federal effort in population research. This report describes research on the development of new means of fertility regulation, the evaluation of contraceptive methods currently in use, and the analysis of social and behavioral determinants and consequences of population size, composition, and distribution. It also discusses the NICHD effort in fundamental research in reproductive biology and the social sciences, upon which advances in contraceptive development and the solution to population problems are dependent. Finally, it describes the Institute's program to support institutions, develop scientific manpower, facilitate the coordination of Federal population research programs, and disseminate population research information.

A. Biomedical Research

1. Contraceptive Development

The contraceptive development program involves research aimed at new approaches to fertility regulation. During fiscal year 1974, important developments have taken place in this program.

a. Drug Development

Drug Synthesis Program. The efforts to produce better chemical contraceptives for both men and women have continued with increasing intensity. The chemical synthesis and the biological evaluation programs have cooperated closely in exploring the contraceptive utility of new chemical entities.

Estrogens (female sex hormones) are potent antifertility agents, constituting an essential component of most currently marketed oral contraceptives. However, estrogens are frequently associated with unpleasant side effects, and, in a few women, present real health hazards.

One aim of the drug synthesis program is to separate the antifertility activity of estrogens from their unpleasant side effects. In this connection, a class of compounds related to estrogen appears promising. Studies are underway in two species of primates to assess the clinical potential of two of these compounds. Information relating to these studies will be available during fiscal year 1975. If promising results are obtained, preclinical drug safety studies will be initiated which will allow their evaluation in man. Within the same class of compounds, work is in progress to find modifications having even greater separations of antifertility activity from undesirable side effects.

Inhibitors of the luteinizing hormone releasing factor (LRF) which are intended to block ovulation have been synthesized and evaluated for biological activity. Even though presently available compounds delay ovulation, their contraceptive utility is limited by their rapid inactivation in the body. Current research involves attempts to develop methods for extending the biological life of these compounds through chemical modifications and through incorporating them into biodegradable drug delivery systems.

Biological Drug Testing Facilities ' Compounds from the drug synthesis program, as well as compounds from other sources, are evaluated for their contraceptive utility at a drug testing facility under contract to the program. The biological testing facility is also utilized to evaluate drug delivery systems. To optimize advanced stages of the drug development program, the CPR has contracted for a new primate (baboon) facility. The present primary aim of this primate facility is to assess the contraceptive efficacy of synthetic estrogens.

New Uses of Existing Drugs. Studies on the safety and efficacy of ethynyl estradiol and conjugated natural estrogens for postcoital contraception are being conducted at four U.S. clinics. While no major problems have been encountered, the incidence of nausea and vomiting is high but can be controlled satisfactorily with anti-emetics. Pregnancies occurred in two women who started ethynyl estradiol medication between 48 and 72 hours following unprotected midcycle coitus. This may indicate the necessity for instituting treatment within 48 hours of exposure for maximum contraceptive efficacy.

Male Contraception. During fiscal year 1975, the NICHD will conduct additional clinical trials to evaluate the contraceptive efficacy and safety of synthetic male hormones. At the laboratory level, activities in male contraception involve (1) synthesis of new androgens (male sex hormones), (2) synthesis of known androgens and their evaluation as male contraceptives, (3) investigation of new drug delivery systems for the maintenance of steady drug levels in the body, and (4) exploration of potential new target sites for contraceptive interference.

The initial clinical trial of chemical contraceptives for men has been completed. This work involved the daily oral administration of a weak synthetic male hormone combined with a once-a-month injection of a potent synthetic male hormone. In most men, sperm numbers decreased significantly after two months of therapy. Such low sperm numbers are considered incompatible with fertility. Sperm numbers returned to normal approximately six weeks after cessation of the therapy. None of the men exhibited undesirable side effects, which lends support to the feasibility of this approach. Future plans call for the expansion of these studies and the search for new chemicals.

b. Device and Systems Development

Drug Delivery Systems. The development of new drug delivery systems has progressed steadily. The aim of this program is to develop biodegradable polymers within which contraceptive drugs may be placed. Theoretically, such a system could deliver the drug at a predetermined steady rate over extended periods of time, eliminating the necessity for daily administration. Since the polymer would degrade slowly in the body to harmless constituents, it would not have to be removed after the drug had been exhausted. Several polymers have been formulated and are being evaluated *in vitro* and in animals. The drugs being used in the drug delivery systems represent both currently marketed oral contraceptives and experimental drugs from the drug synthesis program.

Long-Acting Injectable. The need for contraceptive methods which would free women from daily pill-taking or other forms of self-medication related to the menstrual cycle or to the time of sexual exposure has been recognized for many years. Long-acting (three to six months) injectable drugs are one potentially promising means for achieving this goal. While several injectables have undergone extensive laboratory and clinical testing, none has reached the U.S. marketplace.

During fiscal year 1975, the NICHD will let a contract for the evaluation of one promising long-acting injectable contraceptive. This long-term project will incorporate the animal studies and clinical trials required by the Food and Drug Administration.

Devices. Two new intrauterine devices (IUDs) are presently being evaluated. An IUD which releases small amounts of the female sex hormone, estriol, has been evaluated in the rabbit. The device without the hormone has no effect on fertility, whereas the device releasing estriol is highly effective. This IUD is being tested in baboons to establish the level of the drug that could be released in the uterine cavity without affecting other body organs.

A soft fluid-filled IUD has been tested in one hundred women volunteers with initial encouraging results. As a consequence, the testing program is being expanded to an additional two hundred subjects. Plans are being developed to compare this IUD to presently marketed IUDs in simultaneous clinical trials.

An instrument known as a steerable hysteroscope is undergoing initial clinical trials in women scheduled for elective hysterectomy. The instrument provides operative access to the openings of the fallopian tubes into the uterus under direct visualization. A series of occlusive devices (tubal plugs) now undergoing evaluation in the baboon will undergo clinical trial in the near future. The hysteroscope will be utilized in the insertion of these plugs. The instrument may also be helpful in the diagnosis and removal of discrete tumors of the uterine wall. By enabling the surgeon to see the inside of the uterine cavity in a safe manner, the hysteroscope could prove to be a valuable tool in the development of new fertility regulating methods.

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The device program is also aimed at making vasectomies or vasal occlusions readily reversible. Several types of devices are undergoing extensive evaluation in a variety of laboratory animals, and successful reversal of infertility to fertility has been accomplished. During fiscal year 1975, a decision will be made concerning the feasibility of this approach to human fertility regulation.

c. Directed Fundamental Research

The directed fundamental research portion of the contraceptive development program is devoted to studying those basic research areas which appear most likely to lead to significant new methods. Such areas include the following:

Oviductal Motility and Ovulation. The transducer development program has produced sophisticated instrumentation for measurement of the muscular forces required for transport of eggs through the oviduct. Some transducers can detect the presence of freshly ovulated eggs in the oviduct, thereby indirectly signaling the time of ovulation. Use of this instrumentation enables investigators to expand the fundamental knowledge of reproductive function upon which new contraceptive approaches can be based.

Tissue-Hormone Interaction. The ability of reproductive hormones to interact with specialized cell components, called receptors, has been extensively explored and is dealt with more fully in the section describing fundamental research activities of the NICHD. These receptors have been isolated in a relatively pure form and utilized as a test system to measure the circulating levels of hormones. Recently it has been shown that such systems can be utilized for pregnancy determination or for the rapid biological evaluation of new drugs. The receptor studies serve as a good example of the translation of fundamental biomedical research into applied sciences.

Sperm Enzymes. Sperm contain enzymes which are required for fertilization. Intensive efforts are underway to identify, isolate, and purify these enzymes. Ascertaining the biochemical characteristics of these enzymes and discovering whether they are unique to sperm could lead to the development of specific enzyme inhibitors which would block fertilization.

2. Fundamental Biomedical Research

The goals of this program, which is the largest single CPR activity, are to expand our understanding of mammalian reproductive processes and to increase the knowledge base essential for such significant technological advances as new contraceptives. This work represents a necessary long-term investment in the mission of CPR.

The basic research projects which may provide the most significant new leads for contraceptive development in the near future are those aimed at elucidating the mechanism of action of hormones in general and sex steroid hormones in particular. Through feedback interaction with the hypothalamus and pituitary gland, sex steroid hormones are intimately involved in controlling such reproductively essential phenomena as the ovarian and menstrual cycles, ovulation, sperm development and acquisition of fertilizing ability, gamete transport, preparation of the uterus and subsequent implantation, embryo development, and parturition. Sex steroid hormones bind themselves to specific proteins called receptors in such target organs as ovaries, testes, and the uterus. The structure of these receptors especially for estrogens and progesterone is being investigated since interference with steroid-receptor interactions could potentially decrease fertility.

Gonadotropins are hormones secreted by the pituitary which act on the gonads (ovaries or testes) to make them produce their respective sex steroid hormones, the estrogens and androgens. Work continues on the types of receptors for gonadotropins during development of the gonads. Changing patterns of gonadotropin receptors in the testis reflect the development of its spermatogenic and hormonal elements. In the ovary, the growth of the cell which produces the ovum depends upon an increase in the cell wall of the number of receptors for gonadotropin. Interference with the number and type of receptors in the growing wall would cause cellular degeneration.

While preventing pregnancy through interfering with blastocyst implantation in the uterus has been a continuing goal of contraceptive development research, recent reports suggest that the blastocyst itself may be a promising site for fertility regulation. The blastocysts of some species appear to initiate implantation by emitting a signal. This unknown signal, believed to be a macromolecule, elicits a uterine response favorable for implantation. Evidence that the rabbit blastocyst secretes a gonadotropin-like material prior to implantation is compatible with macromolecular identity of such a signal. Whether the human preimplantation blastocyst secretes such a substance required for its own implantation is not yet known.

More progress has been made recently in understanding the processes involved in sperm production than in the past several decades. Sperm production is controlled by two male sex hormones, testosterone and follicle stimulating hormone (FSH). Testosterone stimulates sperm production, and FSH stimulates production of a protein (Androgen Binding Protein - ABP) to carry testosterone to those parts of the testis where sperm are produced. This new information suggests three possibilities for the development of male contraceptives: (1) A male contraceptive might prevent the transport of testosterone by ABP by blocking the binding of the hormone to the protein, (2) A male contraceptive might act by

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blocking the secretion of FSH by the pituitary gland, or (3) A male contraceptive could prevent production of the ABP required for testosterone action.

Research on two inhibitors in ovarian follicles has provided significant new leads for contraceptive development. Small follicles appear to contain a substance which inhibits the formation of the corpus luteum (the ovarian structure which secretes progesterone). Egg development within the follicles appears to be blocked by a second inhibitor. If these inhibitors could be identified, they could be used to restrict fertility by blocking the progesterone required for pregnancy or by preventing maturation of the egg. These new findings offer especially promising approaches to fertility regulation because the inhibitors are naturally occurring substances which, therefore, might produce minimal undesirable side effects.

A final important new development in the fundamental biomedical research program is the extensive progress made in research on the luteinizing hormone releasing factor (LRF), a substance which indirectly causes ovulation by stimulating the release of another hormone (LH). Much of this research is aimed at the manufacture of LRF-like substances which will block the action of LRF in inducing ovulation or cause ovulation to occur predictably. Synthetic LRF-like substances may prove to be of great value in both regulation of fertility and alleviation of infertility. They may prevent ovulation by blocking the normal response of LH to LRF stimulation. They promise to improve the reliability of the rhythm method by fixing the time of ovulation, thereby defining a truly safe period.

3. Contraceptive Evaluation

To date the contraceptive evaluation program has focused on oral contraceptives and vasectomy. As a consequence of recent developments, a significant new initiative will be undertaken in the area of IUDs.

Long term surveillance of a large population of women has revealed an increase in average systolic and diastolic blood pressure and a six-fold increase in risk of hypertension among oral contraceptive users. Oral contraceptive use is also associated with a decrease in glucose tolerance, an increase in body weight, an increase in blood coagulability, and an increase in certain blood lipids. Continuing surveillance of this population is designed to identify to what extent such effects on known risk factors in cardiovascular disease can be used to identify subpopulations of oral contraceptive users likely to develop subsequent cardiovascular complications.

Studies also suggest a tendency among oral contraceptive users towards vitamin B6, folic acid, and zinc deficiency. Further investigations will attempt to ascertain the clinical significance of these deficiencies.

A series of new projects have been developed to pursue the relationships, if any, between various contraceptive methods currently in use and birth defects. The projects will evaluate oral contraceptives, the rhythm method, spermicidal agents, and IUDs. In addition to investigations of specific malformations suspected of being associated with oral contraceptives such as congenital heart disease and limb malformations, the studies will investigate other types of malformations.

Studies of the effects of oral contraceptives in various animal species will provide a basis for assessing the relative usefulness of each species as a research model for predicting effects in man.

Vasectomy

Studies to investigate possible adverse consequences of vasectomy are continuing. Two types of antibodies to sperm have been found in blood specimens from patients both before and after vasectomy. One type is present is half the patients before vasectomy, increases slightly two months after the operation, and subsequently shows little change. The other type is rare before vasectomy, increasing in incidence the longer the interval after the operation. These two types of antibodies are directed to antigens on different regions of the sperm surface. The possible medical significance of these antibodies will be investigated.

Studies are being conducted relating to the swollen sperm head antigen of human sperm identified during fiscal year 1974. Its chemical composition has been ascertained, and antibodies to it have been detected in 11 percent of 100 men vasectomized from one to four months and in 23 percent of men vasectomized for 12 months. Since the swollen sperm head antigen is of nuclear origin, the possibility of its cross reacting with nuclear material from non-reproductive tissues is being examined.

Several prospective clinical studies are investigating immune function before and after vasectomy. These studies have discovered circulating antibodies to sperm, some fluctuations in tests for cellular immune responses, and low levels of anti-nuclear antibodies in a small number of patients. Since these effects may be transient and unrelated to vasectomy, further studies are required. A prospective study of hormone levels in vasectomized men, initiated during fiscal year 1974, continues to reveal no adverse effects of vasectomy.

Program Development

During fiscal year 1975, a program will be developed to identify factors predictive of hypertensive response among oral contraceptive users and to evaluate the extent to which the hypertensive response is responsive to therapy after discontinuation of oral contraceptives.

Intrauterine devices are now used as a means of birth control by more than three million women in the United States. The efficacy,

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frequency of minor complications, and expulsion rate of these devices have been well documented.

Serious complications and even a number of maternal deaths have recently been associated with IUDs. Available information suggests that severe complications are rare, but that the rate may vary for different devices. The infrequency of serious complications associated with IUDs would make a prospective investigation of this problem excessively costly and time consuming. Therefore, the NICHD will utilize a retrospective case-control research strategy to delineate the risk of specific severe complications, including maternal deaths, for all intrauterine devices currently in use and to identify subpopulations of women at high risk of such complications.

Because of the rarity of severe complications, even a case-control study will require the participation of approximately twenty major hospital centers in the country, using a common protocol and reporting information on cases and controls to a central coordinating unit.

During fiscal year 1975, the NICHD plans to initiate a study to determine the medical status of a large number of men vasectomized over the past several years. Such a study could rapidly provide an overall assessment of the possible medical consequences of the procedure. The NICHD also plans additional studies on purification of sperm antigens since purified antigens are required for improved methods of testing for cell-mediated responses to sperm.

B. Behavioral Sciences Research

The goals of the NICHD behavioral sciences program in population research are: (1) to ascertain the social, psychological, and economic determinants of fertility in the United States and (2) to assess the effects of population size, composition, and distribution.

1. Fertility in the United States

The National Fertility Survey of 1970 showed that white women married at 20 years of age or older tend to use more effective contraceptives than women married prior to age 20. This is not true of black women. Also an increasing proportion of women married during the 1960's used contraception prior to first pregnancy. Oral contraceptives were preferred over other methods by both Catholic and non-Catholic whites. However, the condom was the most frequently used first method among blacks. Another study indicated that couples who had used relatively effective contraceptive methods in early birth intervals showed lower average fertility. Several new studies are being initiated to ascertain the factors which influence the selection and utilization of contraceptive methods. According to the National Fertility Survey, during their first year of exposure to risk of pregnancy, twenty-six percent of

couples using contraception fail to delay a pregnancy they wish to postpone. Only 14 percent of such couples fail to prevent a birth they do not want at any time.

Investigators in Hawaii have conducted a study on the decision-making process regarding abortion. The study is based on survey data collected from over half of the women who conceived during a specific two month period in 1971 and who either carried their pregnancy to term, or who had a legal abortion. Women who had a stillbirth, a spontaneous abortion or an illegal abortion were not included. It was found that coitus was anticipated by the majority of women, but pregnancy was not planned for 58 percent of the women. Two-thirds of the women who did not want to become pregnant were not using a contraceptive method; yet, regardless of whether birth control was used or not, one of three women chose to have an abortion. The decision to have an abortion usually depended upon the woman's marital status, age, religion, and previous use of birth control. While no strong relationship seemed to exist between the types of contraceptive technique used and the decision to have an abortion, women who planned ahead to have an abortion if they became pregnant, were more often using contraception. This implies that for these women abortion was being used as a back-up method for failed contraception rather than a primary method of family planning.

Between 1970 and 1971, teenage illegitimacy dropped 10 percent in states with liberalized abortion policies but rose slightly (0.3 percent) in other states. White teenagers were the only group with rising legitimate birth rates between 1965 and 1970. However, in 1971 their marital fertility declined in states with liberalized abortion policies and continued to rise in other states.

A study of New York City women with recent first births indicated that a substantial proportion wishes that their first child had come later. Nearly 60 percent of the first births were unplanned, and more than a third were conceived out of wedlock. Inadequate knowledge of contraception and low motivation to avoid an unplanned pregnancy appear to be primary factors in pregnancies among women who are not seeking pregnancy.

The relationships between women's fertility and such factors as early labor-force participation, career aspirations, social and psychological pressures, and job status are being investigated. An analysis of 1970 Census data shows that education modifies the relationship between female employment and fertility. While approximately 23 percent of all white married women with a child under five worked in 1970, 34 percent of this group who had more than a college education worked. Other studies are exploring the extent to which this higher frequency of employment in spite of equal parity is the result of greater commitment to a career, greater ability to pay for childcare services, or other factors.

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2. Trends in Fertility and Factors Contributing to Fertility Decline

Data from married women aged 18-39 indicate a continuing decline in the number of births to date as well as in the total number of children expected. Young women anticipated smaller completed families than did older women. Seventy percent of the young wives expected no more than two children, whereas only 40 percent of the older wives actually had families that small. One current study is examining the impact of women's norms concerning family size. In this study, women with no children or one child are perceived as less likable, less well-adjusted, and more selfish than the same women when presented as having two children. The strongest negative reaction is toward the women presented as having no children.

According to one investigator, variations in economic distress have played a significant part in the rise and fall of fertility since World War II. The findings support the hypothesis that the post-war baby boom arose from circumstances that produced a feeling of unusual affluence among young adults. In contrast, young adults who grew up during the prosperous conditions of the 1950's found it more difficult to achieve their higher material aspirations. This condition contributed to the continuing decline in fertility among young adults which began in the early 1960's. The investigator believes that oral contraceptives, liberalized abortion, and the women's liberation movement may have reinforced the impact of economic factors in inducing a decline in fertility. Four new studies will further explore the social and economic determinants of fertility trends in the United States between 1940 and 1970 -- the period of the baby boom and the subsequent fertility decline.

A study of the values associated with family size suggests that the anticipated rewards of children are most important in the decision to initiate family growth but that the recognition of the costs of children is most important in the decision to terminate family growth. The poor have more children and relative to means, pay more for them. Future studies will focus on the perceived economic, physical, psychological, and social costs of children for parents.

A long-term study of fertility in Taiwan shows two important changes: (1) a significant decline in desired number of children in all strata of the population, and (2) a large increase in contraceptive practice among young women, following a long period in which birth control was mainly adopted by older women. According to the results of a longitudinal study, Taiwanese women who desire no more children are successful in having no more.

3. Distribution of Population Growth and Migration

An analysis of migration trends in the U.S. during the 1960's

showed that blacks continued to migrate away from the South although the volume and rate of out-migration were lower than in the two previous decades. While the South and North historically experienced a net out-migration of whites and the West gained, this pattern no longer holds. The North continues to experience a net loss of whites through out-migration but the South is now gaining. There is no evidence of a substantial in-migration of northern-born blacks to the South nor does there appear to be a substantial return migration of southern-born blacks to the South. During the 1960's, the out-migration from rural areas and the concentration of both races within metropolitan areas continued.

4. Consequences of Population Growth

Data from a national sample of high school students indicate that even when socio-economic status is controlled, children from larger families tend to have lower measured intelligence quotients and lower academic skills. While parents accurately perceive many of the advantages of small families, there are still a number of misconceptions. The beliefs that there is a "middle child problem," that single children are spoiled, or that large families offer substantial advantages over small ones are not supported by the currently available research.

Small families appear to promote better physical care of the children. More physical, emotional, and financial resources are available to children in small families. Since social interaction between parents and children is greater in the small family, children may receive more interest, encouragement, and love. However, the increased social interaction can produce negative consequences if parents invest too much in the children and place too great a burden on them to live up to parental expectations. Such stresses may produce emotional disturbances in some children.

Since large families more frequently include unwanted children, researchers must control for the effects of unwantedness in investigating the effects of family size. In one study, children born to women who have been denied abortion demonstrated lower academic performance in all subjects in school than "wanted" children.

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C. Institutional Development

1. Population Research Centers and Program Projects

In addition to project grants and contracts, NICHD supports population research conducted in Population Research Centers and Program Projects. Center Awards support facilities and services to improve the quality of ongoing programs. During fiscal years 1973 and 1974, Population Research Center Awards supported the following ten institutions for the studies noted: 1. Vanderbilt University - reproductive hormone actions and their molecular controls; 2. The University of Texas at Austin - population dynamics of minority groups; 3. Population Council at the Rockefeller University - fertility regulation and antecedents and consequences of fertility; 4. University of Wisconsin - demography and human ecology; 5. University of Chicago - reproductive biology and population genetics; 6. Harvard University - reproductive biology and human reproduction; 7. Johns Hopkins University - fertility in teenage women, family planning services, and fertility regulation; 8. Baylor Medical College - molecular biology of reproductive processes; 9. University of North Carolina - behavioral-social population problems; 10. Columbia University - research by the International Institute for the Study of Human Reproduction. Early in fiscal year 1975, Center Awards will be made to Princeton University for studies in demography and to the University of Pittsburgh for research in primate reproduction.

Program Project Grants are awarded to institutions for the support of multi-disciplinary research programs consisting of at least three interrelated projects. During fiscal year 1973, six Program Projects received support. During fiscal year 1974, eleven Program Projects were supported for the studies indicated: 1. Columbia University - reproductive endocrinology relevant to problems of human reproduction; 2. The University of Michigan - reproductive endocrinology from molecular to physiological levels; 3. The Northwestern University Medical School - molecular, cellular, and tissue mechanisms operative in the action of hormones upon target cells and tissues; 4. The Oregon Regional Primate Research Center - factors which control the events culminating in fertilization in nonhuman primates; 5. The University of Pennsylvania School of Medicine - biochemical, biological, and morphological events in the early processes of reproduction and development prior to implantation; 6. The University of Texas at Austin - control mechanisms at molecular to organismic levels; 7. Harvard University Medical School - reproductive biology, fertilization, embryogenesis; 8. Case Western Reserve - reproductive biology, events from ovulation to implantation; 9. University of Texas at Houston - male reproductive function; 10. University of California at San Diego - gametogenesis and reproductive biology; 11. Washington University - hormonal regulation of the reproductive tract.

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2. Manpower Development

All NIH research fellowships are being phased-out. Therefore, no new applications (with the exception of applications for Research Career Development Awards) are being accepted.

A new Training Program authorized under Title I of the National Research Service Award Act of 1974 will provide for future NIH training activities. Regulations for this program are currently being prepared.

D. Coordination and Communication

The coordination of Federal population research programs and the communication of population research information is accomplished through the following activities:

Interagency Committee on Population Research

The Interagency Committee on Population Research (ICPR) coordinates the population research activities supported by Federal agencies and fosters the exchange of information among Federal population research programs. The Committee was established by the Secretary of HEW on October 5, 1970, and has been extended through June 30, 1976. The ICPR is chaired by the Director of NICHD's Center for Population Research and reports to the HEW Deputy Assistant Secretary for Population Affairs.

Inventory of Federal Population Research

An important product of the ICPR is the Inventory of Federal Population Research which has been updated annually since fiscal year 1969. It represents a cooperative effort on the part of the Federal agencies that fund population research projects. The Fiscal Year 1973 Inventory reports that Federal agencies supported about $54 million in population research during fiscal year 1973, approximately 11 percent less than the $61 million obligated in fiscal year 1972. An additional $23 million was invested in generating statistical data directly relevant to population research, a decrease of about $5 million from fiscal year 1972. This decrease was due to completion of much of the work on the 1970 Census. There was a slight decline in the total number of projects sponsored by Federal agencies, from 767 in fiscal year 1972 to 730 in fiscal year 1973. DHEW continued as the major Federal funding agency for population research, providing $44.1 million or 81 percent of the fiscal year 1973 total.

Analysis of Federal Population Research

The ICPR also prepared its Analysis of Federal Population Research -- Fiscal Year 1973. This annual report analyzes current Federally

supported population research and recommends research to meet information gaps in the population sciences.

Population Sciences: Index of Biomedical Research

Population Sciences: Index of Biomedical Research, a bibliographic journal published on a monthly basis, provides information concerning current biomedical research literature in the population sciences. Beginning with the September 1974 issue, the journal will be available only through a subscription placed with the Superintendent of Documents.

Population Research Monographs

The NICHD also disseminates population research information through publication of monographs. The monographs review and evaluate specialized areas of population research in the biomedical or social sciences and indicate the research required to obtain needed knowledge. Research monographs currently in press or final preparation include: The Walnut Creek Contraceptive Drug Study; Rural-Urban Migration Research in the United States; Handbook of Steroid Contraceptives; Fertility of the Yugoslav Population; and Population Psychology: Research and Educational Issues.

Publications of Workshops and Conferences

The publications resulting from NICHD conferences and workshops constitute a valuable addition to population research literature. Books added during fiscal year 1974 include: Biorhythms and Human Reproduction; Proceedings of a Research Conference on National Family Planning; and Oral Contraceptives and High Blood Pressure.

SOCIAL AND REHABILITATION SERVICE

Community Services Administration

Family planning services are included in the Social Services Program authorized under Titles I, IV, VI, X, XI, XIV, and XVI, of the Social Security Act (SSA).[1/] Administration of these programs is in the Community Services Administration.

Current recipients of public assistance under Aid to Families with Dependent Children (AFDC), Aid to the Aged, Blind, and Disabled and Supplemental Security Income (SSI) are eligible to receive family planning services. States may also choose to provide family planning services to potential recipients of cash assistance under these three programs.

Family planning services include the provision of information, personal counseling, medical services, payment for medical services, referral for medical care, follow-up of medical referrals, provision for transportation and child care arrangements so that parents may obtain medical care, and the development of medical resources when none exist.

The Social Security Amendments of 1967 (P.L. 90-248) required that under SSA Title IV-A, family planning services were to be offered in all appropriate cases. Acceptance of such services was to be voluntary and was not to be a prerequisite for or impediment to eligibility for the receipt of any other service or financial aid.

The Social Security Amendments of 1972 (P.L. 92-603) provided significant new incentives for the provision of family planning services. This Act makes the informing of the availability and the prompt provision of family planning services mandatory to all present recipients of AFDC who are of childbearing age and imposes a penalty of one percent per annum on the Federal share of AFDC funds on States which failed to provide these services in the previous year to eligible persons desiring them. In addition, the Act increases the Federal share of matching for family planning services under Social Services from 75 percent to 90 percent.

The requirement that States offer and provide promptly upon request family planning services to eligible individuals has resulted in an increase in State family planning program activities. Staffs of public agencies are available to provide referral to a medical resource and other assistance needed to enable individuals to obtain services. Federal instructions to States as to when the offer of family planning services is to be made (within 31 days of the first assistance payment and once a year thereafter) and the placement of a 30-day time limitation within which a request for services must be met have assisted the States in complying with the requirements of P.L. 92-603.

Although there is a favorable Federal matching rate of 90 percent for family planning services, it should be noted that such services are included under the overall annual $2.5 billion ceiling on social services expenditures under SSA Title IV-A.

1/ Effective January 1, 1974, SSA Titles I, XIV, XVI, and X services were provided under new SSA Title VI, except for Guam, Virgin Islands, and Puerto Rico.

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Medical Services Administration

The Social Security Act of 1965 (P.L. 89-97--approved July 5, 1965) added Title XIX, "Grants to States for Medical Assistance" to the Social Security Act. Under the Federal-State medical assistance program which it established, known as Medicaid, States participating in the program were required to provide medical assistance to all recipients of cash assistance. At State option, they could also finance medical care for the medically needy, i.e., those persons who would otherwise be eligible for cash assistance except that the level of their income is sufficient to sustain themselves, but too low to provide necessary medical care. In addition, States could opt to provide coverage to children under 21 from low-income families.

Under the original legislation, inclusion of family planning services was a State option. However, P.L. 92-603, passed in October 1972, made coverage of family planning services for cash assistance recipients under Title XIX mandatory on the States. In addition, the rate of Federal financial participation for family planning services for both the categorically and medically needy was increased to 90 percent on the date of enactment of the Bill.

Medical assistance for family planning includes payments for appropriate medical examinations, diagnosis, medical counseling and treatment, laboratory services, surgical procedures, drugs, supplies and devices. These services may be provided in doctors' offices, clinics, hospitals (on both an inpatient and outpatient basis), family planning centers, or any other suitable settings.

Because of the increased responsibilities placed on the State agencies to assure that family planning services are offered and available to all eligible persons who wish to utilize them and the increased Federal matching, a sizeable increase is expected in Title XIX expenditures for family planning from FY 72 through FY 75.

V

EDUCATION DIVISION

Office of Education

The Office of Education (OE), through its various grant programs, enables educational institutions at all levels to include family life, sex education and population education in their programs. In addition, OE provides limited Federal support for innovative family-related projects. All decisions concerning curriculum, teaching methods, qualification of teachers, and classroom materials are made by state and local authorities acting within the framework of state law.

Elementary and Secondary Education

The Elementary and Secondary Education Act of 1965 (P.L. 89-10) and its amendments provide several titles under which family life and sex education activities are eligible for support.

Title I, Grants for the Disadvantaged, assists in expanding and improving educational programs aimed at meeting the special needs of educationally deprived children. Through payments to state education agencies, grants are made for children from low-income families, handicapped children, delinquent or neglected children, and migrant children. Further, payments are made to the Secretary of the Interior for grants to benefit Indian children in federal schools administered by the Bureau of Indian Affairs as well as out-of-state Indian children in elementary and secondary schools. Recipients of Title I grants may use the funds for projects relating to dropouts, pre-schoolers, teen-age unwed mothers, and other approaches for remedying education deprivation. However, the components of these projects which are concerned with family life and sex education are not identifiable per se.

The purpose of ESEA Title III, Supplementary Educational Centers and Services, is: to enable schools to provide programs currently unavailable to children; to improve educational services already offered; and to stimulate the development and evaluation of experimental elementary and secondary educational programs which can serve as models. Fifteen percent of program funds is mandated for projects serving handicapped children. Other funds are mandated for projects in guidance, counseling and testing. Although not dealing directly with family life and sex education, Title III projects in environmental education provide information on population environmental affairs.

Originally, the Commissioner of Education made grants directly to local education agencies. Beginning in fiscal year 1971, 85 percent of Title III funds were to be administered by State education agencies, with fifteen percent to be used at the Commissioner's discretion within the State.

The Dropout Prevention program, Title VIII, Section 807 of the Elementary and Secondary Education Act, has no family planning projects as such. However, several projects for pregnant women in fiscal year 1974 included components related to family planning such as pre- and post-natal care, personal counseling, and child care. Under this program, funds are used to support demonstration projects designed to reduce the number of dropouts in low-income areas and in areas where a high percentage of children do not complete their elementary or secondary school education. Since pregnancy and/or early marriage constitute the largest cause of dropout by teen-age girls, the need for inclusion of family life and sex education in a comprehensive school program is apparent.

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Vocational Education Program

Under Grants to States for Vocational Education, the Consumer and Homemaking Education Program (P.L. 90-576, Part F) supports a number of projects with components relating to family life and child care.

For Example:

-- Family planning may be included in the study of family relationships, marriage, and child care offered in vocational home economics education courses for secondary and post secondary students. Although some portion of instructional time is concerned with family planning, this activity cannot be identified per se. The decision to include a study of family planning in the home economics courses is made by the local community.

-- Courses in child care/development which offer preparation for parenthood are being emphasized in consumer and homemaking education programs for both youth and adults. Enrollment in specialized courses on this subject increased from 4,038 in fiscal year 1966 to 172,976 in fiscal year 1973. Child development laboratories are part of the home economics facilities in most high schools in Montgomery County and Prince Georges County, Maryland. Full year courses in child development from the pre-natal stage through childhood are offered at these high schools for students, grades 10 to 12. Additionally, enrollment in family relations courses has expanded from 95,367 in fiscal year 1967 to 210,973 in 1973, with an estimated enrollment of 250,000 in 1974 and 1975. A total of approximately 2.2 million youth and adults received family life education and child care instruction in FY 1973.

-- Teenage-parent programs, offered under the auspices of the home economics department in many schools, are now making it possible for young parents to continue in school. For example, in Berkeley, California, a child care center is provided by the school for the infants and children of school age parents. Young mothers and fathers as well as other students enrolled in child development courses participate in caring for the children in the center under the guidance of a teacher. In the Granite School District in Utah, a special homemaking center has been set up for pregnant teenagers, both married and unmarried, who do not want to continue in the regular school program. Consumer and homemaking education programs are providing specific assistance to expectant young parents in caring for their babies and assuming their future responsibilities.

-- In one community in Wisconsin, enrollment in courses in family living is required of family court clients. Attending these courses are single parents, parents of youth from poor socioeconomic areas, potential school dropouts, delinquents, unwed parents and foster parents.

-- A family life education TV series developed by a community college in Oregon last year reached 5,000 people. Each of the 15 lesson series on "Living with Your Child" was followed with a discussion group led by a parent educator.

-- In cooperation with local public housing authorities, school districts in major cities of Ohio, Georgia, Washington, Texas and other States are providing Family Life Education Programs for low-income families. Classroom space (one or two apartments), large equipment and some supplies are made available by the housing authorities.

-- In Wisconsin, credit courses in "Marriage for the Now Generation" are being offered in postsecondary vocational schools. In Georgia, 26 postsecondary schools offer courses in consumer and family life skills.

-- The number of consumer and homemaking education programs in middle and junior high schools is growing rapidly. In South Carolina, the program is offered for sixth, seventh, and eighth graders, focusing on four areas: personal relationships, personal health, personal environment, and personal development. In Pennsylvania, programs are offered to fifth and sixth graders. Classes are either held in the home economics department or in the elementary school classroom.

-- In Alburquerque, New Mexico, a special program in child development is being offered for 9th grade Spanish American girls in a school where the drop-out rate prior to the course was 40 percent. The drop-out rate at the school has been reduced substantially since the program's inception in 1970.

Adult Education Program

The Adult Education Program authorized by the Adult Education Act of 1966, as amended, (P.L. 91-230, Title III and P.L. 93-380), is designed to serve under-educated adults, primarily those with less than an 8th grade education. The program's primary objective is to enable the adults who participate to become employable, productive and responsible citizens as well as self-reliant and competent individuals, parents and family members.

Through grants to state departments of education matched by state and local funds, opportunities are provided in local communities for adults to improve their learning and communication skills -- reading, speaking, writing -- and their computation skills. Family-related concerns of participants, many of whom are parents and heads of families, are reflected in the curricula and there is an increasing emphasis on home management, consumer education, nutrition, family development, family planning, and parent education. The "Family Development Series" of materials for Adult Education participants is widely used, as are other family-related materials.

In an increasing number of communities, the local adult education program provides classes for mothers of children in Head Start and Parent Child Centers. Activities are carried out in cooperation with Home Start and the Child and Family Resource Center models being developed by the Office of Child Development to serve children and their families. It is estimated that $13,000,000, 20% of the total Adult Education effort under the State grant program, is concerned with some aspect of family-related education.

In addition to the State grant programs, funds were authorized (P.L. 91-230, Title III, Section 309) through FY 1974 for Special Experimental and Demonstration projects and for a regional teacher training program. Forty-seven grants totaling $6,561,979 were awarded in FY 1974 for Special Experimental and Demonstration projects with an estimated $1,250,000 supporting family-related projects. Several demonstration projects funded in FY 1973 under the priority "education for disadvantaged parents" were again funded in FY 1974. These and other experimental projects concerned with family-related content are demonstrating a variety of techniques and delivery systems.

For example:

-- In cooperation with Home Start in northern Alabama, home visitors help parents use a special television program and materials in acquiring their high school certificates.

-- Through home visits, Spanish speaking parents in Arizona are helped to gain skills and knowledge needed for parent participation in their children's school. Other Spanish speaking parents of Head Start children in California are helping to develop and test bilingual "parenting skills" materials.

-- An adult education model designed to improve the life styles of female solo parents is being developed by the National Council for Negro Women.

-- Materials emphasizing family-related needs are being developed for blacks in rural communities in Alabama.

-- In Arkansas, unemployed rural male heads of families are the participants in an individualized instruction project.

-- Undereducated Samoan parents in Honolulu are participating in family-focused education involving peer instruction.

-- A Family Learning Project in Iowa involving adults and children teaches mothers to help their children learn to read.

-- An alternative delivery system involving home-based pre-school parent education, developed jointly by Granite School District (Utah) and Los Angeles City School District, is being prepared for use by other communities in expanding Adult Basic Education programs through parent and family education.

Under the staff development and teacher training program authorized by P.L. 91-230, Title III Sec. 309, training project grants for fiscal year 1974 totaled $3,434,720. Of this total, an estimated 10% or approximately $300,000 was expended for training teachers in parent and family-related activities.

For FY 1974, total expenditures in State Grant and discretionary programs for family-related adult education were approximately $14,550,000. Under the Adult Education Act, as amended by the Education Amendments of 1974 (P.L. 93-380), all discretionary funds are allocated to the States beginning in fiscal year 1975. The FY 1975 appropriation for the States is expected to be $67,500,000. Estimated expenditure for family-related education for FY'75 is $13,500,000.

Higher Education

Title I of the Higher Education Act of 1965 (P.L. 89-329) provides financial support to encourage colleges and universities to assist in the solution of community problems through specially designed continuing education and community service programs. A State desiring to receive its allotment of Federal funds under this Title must designate or create a State Agency which is required to submit an annually amended State plan to the U.S. Commissioner of Education for approval. The plan must set forth administrative policies and procedures and identify community problems it wishes colleges and universities to address. The State Agency reviews proposals from institutions of higher education and awards funds to approved projects on a 66 2/3 percent Federal and 33 1/3 percent non-Federal matching basis. No funding is appropriated for Title I in FY 1975 and there is no request for funding in FY 1976. Of the $14,250,000 FY 1974 appropriation for Title I, $235,000 was allocated for family planning activities under the Grants to States for Community Service and Continuing Education program.

VI

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
POPULATION RESEARCH AND FAMILY PLANNING ACTIVITIES

Obligations, FY 1972 -- FY 1976

Agency and Program	Fiscal Year				
	1972	1973	1974	1975(Est.)[1]	1976(Est.)
Total, Department of Health, Education, and Welfare	$198,661,000	$228,860,000	$305,635,000	$294,829,000	$258,730,000
PUBLIC HEALTH SERVICE					
Health Services Administration					
Bureau of Community Health Services (BCHS)					
Maternal and Child Health					
Formula grants to States	$ 11,700,000	$ 11,700,000	$ 11,700,000	$ 43,600,000	$ 28,000,000
Project grants for maternity and infant care	4,500,000	4,500,000	4,500,000	---	---
Research	200,000	100,000	100,000	100,000	---
Family Planning	96,656,000	107,207,000	149,491,000[2]	100,615,000	79,435,000
Subtotal, BCHS	113,056,000	123,507,000	165,791,000	144,315,000	107,435,000
Bureau of Medical Services	386,000	268,000	227,000	244,000	261,000
Indian Health Service	754,000	896,000	1,061,000	1,523,000	1,854,000
Subtotal, Health Services Administration	114,196,000	124,671,000	167,079,000	146,082,000	109,550,000
Center for Disease Control	212,000	378,000	253,000	368,000	400,000
National Institutes of Health					
National Institute of Child Health and Human Development	39,973,000	39,844,000	51,025,000[3]	51,006,000	41,885,000

1/ Excludes the President's proposed rescissions.
2/ Includes $15 million previously administered by the Office of Economic Opportunity; also includes $30 million authorized under the FY 1973 continuing resolution, released for obligation in FY 1974.
3/ Includes $6.5 million authorized under the FY 1973 continuing resolution, released for obligation in FY 1974.

Obligations, FY 1972 -- FY 1976 (Cont'd)

Agency and Program	Fiscal Year 1972	1973	1974	1975(Est.)[1/]	1976(Est.)
Health Resources Administration					
National Center for Health Statistics	$ 842,000	$ 461,000	$ 791,000	$ 733,000	$ 2,394,000
Office of the Assistant Secretary for Health					
Office of International Health					
Scientific Activities Overseas (Special Foreign Currency Program, P.L. 480)[4/]	726,000	909,000	342,000	---[5/]	1,000,000[5/]
Total, Public Health Service	$155,223,000	$165,354,000	$219,148,000	$198,189,000	$154,229,000
SOCIAL AND REHABILITATION SERVICE					
Social Services	28,200,000	38,872,000	40,800,000	46,900,000	51,600,000
Medical Assistance	8,700,000	18,200,000	30,600,000	36,000,000	38,200,000
Total, Social and Rehabilitation Service	$ 36,900,000	$ 57,072,000	$ 71,400,000	$ 82,900,000	$ 89,800,000
EDUCATION DIVISION					
Office of Education					
Elementary and Secondary Education					
Supplementary Education Centers and Services (ESEA III)	582,000	582,000	272,000	240,000	136,000[6/]

4/ Not included in the PHS or DHEW total. All obligations are in U. S. - owned excess foreign currencies.
5/ No new obligational authority has been requested for this appropriation for FY 1975 or FY 1976. All obligations will be made from funds appropriated but unused in previous years.
6/ Funds to be consolidated under the support and innovation grants consolidation program in FY 1976.

Obligations, FY 1972 - FY 1976 (Cont'd)

Agency and Program	Fiscal Year				
	1972	1973	1974	1975(Est.)[1/]	1976(Est.)
Dropout Prevention (ESEA VIII, Sec. 807).....	$ 40,000	$ 40,000	$ 30,000	---	$ 15,000
Adult Education.....	5,578,000	5,613,000	14,550,000	$ 13,500,000	14,550,000
Higher Education					
Grants to States for Community Service and Continuing Education.....	338,000	199,000	235,000	---	---
Total, Education Division.....	$ 6,538,000	$ 6,434,000	$ 15,087,000	$ 13,740,000	$ 14,701,000

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

REPORT ON HEARING AND SPEECH

A REPORT TO THE

HOUSE COMMITTEE ON APPROPRIATIONS

HEARING AND SPEECH

Obligations Fiscal Year 1972 to Fiscal year 1976

Agency and Program	1972	1973	1974	1975	1976
OFFICE OF HUMAN DEVELOPMENT					
Rehabilitation Services Administration:					
Basic State grants..	$32,480,000	$34,751,000	$37,170,000	$39,440,000	$37,400,000
Innovation grants...	-	-	-	-	-
Service projects....	310,000	280,000	140,000	140,000	-
Rehabilitation training.....	832,540	3,767,067	270,800	270,800	1,150,000
Rehabilitation Research and demonstrations.....	1,678,000	1,000,000	250,000	180,000	180,000
Rehabilitation Research and training centers..	354,000	400,000	480,000	500,000	500,000
Special foreign currency program..	513,725	400,000	-	200,000	450,000
Total, RSA.....	$36,168,265	$40,598,067	$38,310,800	$40,730,800	$39,680,000

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HEARING AND SPEECH

Obligations Fiscal Year 1972 to Fiscal Year 1976

Agency and Program	1972	1973	1974	1975	1976
OFFICE OF EDUCATION:					
Elementary and secondary	$ 14,000,000	$ 19,800,000	$ 15,200,000	$ 15,800,000	$ 13,900,000 1/
Education for the handicapped	34,645,000	32,795,771	44,034,537	48,015,158	57,050,000
Occupational, vocational, and adult education.	4,729,500	4,883,200	4,800,000	4,800,000	1,000,000 4/
Library resources.	40,000	50,000	40,000	40,000	30,000
Research and Training	68,143	2/	---	---	---
National Advisory Committee on the Handicapped	3/ 100,000	26,081	32,484	100,000	100,000
Subtotal, Office of Education	$ 53,582,643	$ 57,555,052	$ 64,107,021	$ 68,755,158	$ 72,080,000
HEALTH SERVICES ADMINISTRATION:					
Community Health Services	$ 3,155,000	$ 3,970,000	$ 3,270,000	$ 2,710,000	$ 2,710,000
NATIONAL INSTITUTES OF HEALTH:					
National Institute of Neurological Diseases and Stroke	$ 11,446,000	$ 10,240,000	$ 12,164,000	$ 10,433,000	$ 12,359,000
National Institute of Child Health and Human Development	10,810,000	11,869,000	15,612,000	13,300,000	13,200,000
National Institute of Dental Research	1,461,102	1,774,053	2,385,227	1,526,883	1,803,709
National Institute of Environmental Health Sciences.	---	212,000	460,000	430,000	400,000
Subtotal, National Institutes of Health	$ 23,717,102	$ 24,095,053	$ 30,621,227	$ 25,689,883	$ 27,762,709
Subtotal, Public Health Service	$ 26,872,102	$ 28,065,053	$ 33,891,227	$ 28,399,883	$ 30,472,709

HEARING AND SPEECH

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Obligations Fiscal Year 1972 to Fiscal Year 1976

Agency and Program	1972	1973	1974	1975	1976
SPECIAL INSTITUTIONS:					
National Technical Institute for the Deaf.....	$ 30,826,000	$ 7,223,000	$ 7,226,000	$ 10,756,000	$ 10,980,000
Gallaudet College.	14,534,000	28,280,000	25,661,000	38,223,000	25,532,000
Subtotal, SI.....	$ 45,360,000	$ 35,503,000	$ 32,887,000	$ 48,979,000	$ 36,512,000
TOTAL, DEPARTMENT OF HEALTH, EDUCATION AND WELFARE.....	$161,983,010	$161,721,172	$169,196,048	$186,864,841	$178,744,709

1/ The programs in these activities which supplied funds for hearing and speech are being consolidated, in fiscal year 1976, into a consolidated education grants program which specifies that 50% of the funds included in the consolidation must be used for the same purposes for which they were used previously. Beginning in 1977, total grant consolidation will be achieved.

NOTE: Of the activities reported from the Elementary and Secondary education appropriation, Title I is not in the consolidation; Title III is.

2/ Program transferred to the National Institute of Education in fiscal year 1973.

3/ From 1972-1973, amounts are for the National Advisory Committee on Education of the Deaf; during 1974 this Committee combined functions with the National Advisory Committee on Handicapped Children to form a new National Advisory Committee on the Handicapped. This activity was previously reported under the Office of the Secretary.

4/ New legislation will be proposed for most of the programs involved. No estimates can be included for those activities.

6 OFFICE OF HUMAN DEVELOPMENT
REHABILITATION SERVICES ADMINISTRATION
SUMMARY OF PROGRAMS FOR THE DEAF, FOR THE HARD OF HEARING
AND FOR THE SPEECH IMPAIRED

Vocational rehabilitation is providing significant new opportunities to men and women with serious communicative disorders to achieve their potential. In opening the way to more and better services to the most severely handicapped, including those with the most severe communicative disabilities, the Rehabilitation Act of 1973 has committed vocational rehabilitation to ever increasing diligence in reaching out and assisting those in need. The legislation adds a sparkling new chapter in the history of vocational rehabilitation advancements benefiting individuals with communicative disorders and heralds an era when many more will be served.

A summary of the most outstanding ongoing and developing vocational rehabilitative activities that are anticipated to increase the number of deaf, hard of hearing and speech impaired persons rehabilitated annually are presented in this report.

The Problem in General

Americans who are vocationally handicapped by varying degrees and kinds of communication disorders exceed 20,000,000 in number. Some have disorders of the ears, the normal channels for receiving verbal messages. Some have defects in the vocal mechanisms, the main means for sending verbal messages. Some have disorders of the central nervous system which interfere with receiving and sending even though the ears and vocal apparatus are whole. Some have peripheral involvements that curb free verbalization. Some have combinations of causes.

The complexity and variety of the causes frequently obscure the fact that speech and hearing are variables that fluctuate with physical, mental and emotional conditions. Normal ears, normal mentality, normal vocal mechanisms and so on should result in normal hearing and normal speech. One abnormality or more results in abnormal communication. The person permanently affected faces formidable barriers. Fortunately, the condition for many is transitory due to the wonders of medicine and related disciplines. These are not among the above-named 20,000,000 whose disabilities are constant, who continuously search for ways to reduce the handicap of communication limitation.

Vocational rehabilitation workers share with teachers, audiologists, speech pathologists, medical workers, and others the responsibility to create, extend and improve knowledge and resources by which the communicatively handicapped can attain adjustments commensurate with their mental and residual physical capacities.

The Deaf

Our 450,000 deaf people have very complex problems. Many of them are without useful speech despite years of training. Many have limited language skills. They receive messages principally through their eyes. They send message by combinations of signs, gestures, speech, and writing. Most of them have normal strength, mobility and intelligence. They strive for achievement within the limiations imposed by society. It is primarily a psychosocial problem. It manifests itself in many ways: underinvolvement in the main stream of community life; limited socializing with fellowmen; lack of acceptance among neighbors, employers and fellow employees; severe underemployment. It seldom yields at all to medical intervention such as drugs, surgery or prosthesis. It does yield in approximate ratio to the availability in quality and depth of training and adjustment services that stem from comprehensive, expert diagnosis that may involve the disciplines of psychology, audiology, medicine, and education and to public relations activities that stress the deaf person's strengths.

Two deep-seated problem areas for vocational rehabilitation exist with respect to deaf people. First, the most basic and achievable need of the deaf person, specifically skill in reading and writing, has until very recently been insufficiently emphasized in childhood training. Formal training has generally so heavily emphasized the development of speech skills in the deaf child that speech has erroneously assumed the position of being the equivalent of rather than a vehicle for language. To put it another way, teachers of the deaf have focused disproportionate time and energy upon an outlet (speech) for language rather than power in language itself. Language and speech have been referred to interchangeably, confusing professional and lay workers alike. Hence, the handicapping aspects of deafness have often been intensified by a needless wall of language deficiency. Developing interest in total communication (use of speech, fingerspelling, signs, gestures, reading and writing in combinations verbal by individual children) by parents and educators as a better means for early language development in deaf people is a promising new movement.

Second, an incorrect image of the deaf person's potential in verbal communication skills stems from this heavy emphasis on speech and frequently unrealistic publicity that generates from it. These together create everywhere an expectancy in oral communication performance which very few deaf people can fulfill. Employers and others are, thus, not conditioned to look beyond the poor speech for the hidden, often rich, human resources.

The Rehabilitation Services Administration is attacking the roots of underemployment: (1) By encouraging and assisting in the establishment of rehabilitation centers to diagnose and train deaf people: (2) by extending its training operations (a) to reduce the communication barrier facing deaf people by developing standards and new procedures for speech conservation, utilization of telecommunications, instruction in manual communication and interpreting, (b) to qualify more professional workers in psychology, social work, vocational rehabilitation, speech therapy and audiology to work with the deaf, (c) to develop better understanding of the potentials of deaf people among vocational rehabilitation workers and others, including employers and community leaders, (d) to improve the understanding among professional and voluntary workers of how they can assist the State vocational rehabilitation agencies in serving the deaf, and (e) to help deaf people and their co-workers develop more productive concepts of community inter-relationships; (3) by encouraging researchers to study and resolve the many economic, social, and psychological problems associated with deafness; (4) by extending assistance in the establishment of post secondary programs for deaf people; (5) by encouraging and assisting universities in opening new professional fields to deaf people through special programs and placement techniques; (6) by aiding parents to become more involved in the rehabilitation of their deaf children; and (7) by bringing into focus the needs and remedial actions that are unique to the civil rights of deaf people.

The Hard of Hearing

The several million hard of hearing pose quite different problems from the deaf, the two groups cannot be treated as one. Whereas the deaf receive verbal communication almost solely through their eyes, the hard of hearing rely principally upon their ears, even though these are defective. The hard of hearing generally have near-normal speech and language. Their disability often had a late onset as opposed to the early affliction of the deaf. Partial hearing impairment is less a psychosocial than a medical problem and often yields significantly and quickly to medical intervention and prosthesis with speedy return to an old job or a new one.

It is known that the number of individuals with partial hearing loss is far greater than those who have lost their hearing completely. How much greater is unknown. More accurate estimates are needed before the full magnitude and vocational significance of this problem can be assessed. Deteriorating job performance, eventual loss of job, and gradual withdrawal from family and society

are three of the more obvious results of gradual and progressive hearing loss. Too few of these people request help from their State divisions of vocational rehabilitation.

The problems of the hard of hearing are many; this the State vocational rehabilitation counselor knows. How best to solve them, no one yet knows. Much remains to be accomplished in helping the hard of hearing person retain the skills he had before the onset of his handicap. Better diagnostic methods need to be developed to permit more successful fitting of hearing aids. Abilities which permit a person to speechread (lipread) successfully are, at present, unidentified. And yet, accurate prediction of such ability would have profound effects on the rehabilitation management of hard of hearing and deaf children as well as adults.

Further attention should also be given to ways of helping the person with progressive hearing loss retain his speech intelligibility while he is losing his major sensory pathway for judging the accuracy of his speech production.

Basic to meeting the vocational rehabilitation needs of our hard of hearing are people to provide the highly specialized services that they need and the places to do it. The Rehabilitation Services Administration is aggressively involved in helping the States to find these fundamental resources.

The Speech Impaired

The speech impaired, including the language impaired, necessarily include many of the deaf and the hard of hearing because normal speech production depends to a great extent upon self-monitoring which in turn depends largely upon the speaker's hearing. We hear ourselves and correct as we go along. It is not the same for the hearing disabled. However, there are also millions of speech impaired whose abnormal or absent output stems from organic disorders other than hearing.

The special needs of stroke victims, particularly those with language problems due to aphasia, have received nation-wide attention. Little is known about the actual incidence of the disability, particularly in its more subtle and partial forms. Also, diagnostic techniques to determine the most appropriate treatment program and the outlook for recovery remain crude and inexact. Unavailability of crucial specialized services within the aphasic's home community particularly language therapy, poses insurmountable problems for most aphasics living outside large metropolitan areas. New methods of extending services to those people and/or training other family members to assume the task must receive high priority. Programmed teaching machines represent one partial solution to this problem, but self-teaching programs must be developed and evaluated. The spotlight of attention given to this affliction merely highlights the problems which are as yet unsolved.

Equal attention has recently been given to cancer victims. In great need of rehabilitation are those who have lost their larynx because of cancer, thus, their ability to produce voice. Such a sudden handicap usually results in loss of job and loss of family responsibility. Training procedures now exist to help the laryngectomees learn to use esophageal speech, but too often those methods fail. Many individuals, therefore, go for the rest of their lives without the ability to speak. Reasons for this failure must be found. Better techniques for identifying those people who will be able to learn esophageal speech--and those who will not--are needed. Programmed learning methods also need to be considered as possible retraining procedures. Pre-surgery personality factors deserve investigation as probable reasons for post-surgery response to rehabilitation efforts.

Stuttering is another wide-spread speech handicap which deserves greater attention. Over 1,000,000 people in the United States suffer from this affliction. The problems of the adult stutterer are particularly damaging and cause the individual to lead a restricted and sterile life. This is true primarily because

the speech defect is variable; the stutterer rarely knows when he begins to speak whether he will talk normally or will produce a spasm of muscular tension and an explosion of distorted words. Most stutterers, therefore, remain constantly "on guard" and resort to bizarre tricks and body motions (which themselves attract attention) to avoid stuttering. Some stutterers even pose as deaf to avoid having to speak. Consequently, many stutterers of superior ability accept jobs which requires little or no talking and remain at a level of employment far below their aspirations and capacities. Underemployment, self-imposed, may sometimes be the stutterer's handicap.

Usually, these problems are most resistant to change, even though most of the stutterer's speech problem has been learned and can be unlearned. The reasons for the tenacity of stuttering are unknown. What is particularly puzzling is the fact that for a few persons, long-time stuttering can be eliminated with relative ease. Clinical observation has indicated that there are different types of stutterers. We need to find ways of identifying each kind and the critical factors which determine their response to rehabilitation. Also, better ways of helping stutterers achieve and retain more normal speech must be found. To do this, better methods of judging the effectiveness of speech therapy are needed. The goal is doubly worthwhile since, if the stutterer's speech can be improved, most of the associated psychosocial and vocational problems which his stuttering creates will also be eliminated.

The State vocational rehabilitation agencies find that a major problem is the lack of guidelines that enable staff to relate speech impairment to occupational handicap. Moreover, standards of casework performance and progress in therapy are not so closely defined nor apparent in speech rehabilitation as in other areas. The resources that serve the hard of hearing can be effective for the Administration's drive for more hearing and speech centers relates to speech rehabilitation, too. Additionally, special emphasis is being given (1) to the development of authoritative literature on the handicapping aspects of speech disorders and their treatment and (2) to the fostering of voluntary work for the speech impaired throughout the national community on a level equal to that for the hearing impaired. The development of casework standards as guidelines for vocational rehabilitation counselors serving speech impaired clients has high priority.

Numbers Served by State Vocational Rehabilitation Agencies

The aim of the public vocational rehabilitation program is the preparation of the occupationally handicapped disabled person for suitable employment. The State vocational rehabilitation agencies actually determine eligibility and provide services using grant-in-aid funds administered by the Rehabilitation Services Administration.

All of the resources of the public vocational rehabilitation services are directed toward the occupational adjustment of the person whose disability is a vocational handicap. The media for attaining this end with each client are the case services that are patterned to individual needs. The research, training, and facility development activities of the Rehabilitation Services Administration and the State agencies are carried on for the purpose of strengthening case service techniques, developing new ones, improving the capacities of the case worker and the personnel upon whom he draws, and developing resources for better diagnostic, evaluation, training and restoration services. The dual aim of sharp increases in the quality and quantity of services and persons served permeates the whole program.

The extent to which the State agencies rehabilitated the deaf, the hard of hearing, and the speech impaired in the fiscal year 1973 and the numbers estimated to be rehabilitated in fiscal years 1974 through 1976 are shown in the following table:

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NUMBER OF REHABILITANTS OF THE STATE VOCATIONAL REHABILITATION AGENCIES WITH SPEECH AND HEARING IMPAIRMENTS, FISCAL YEARS ENDING JUNE 30, 1973-1976

	Estimated and actual number of rehabilitants in fiscal year 1/			
	1973	1974	1975	1976
All rehabilitants	360,726	361,138	363,000	332,000
Number of rehabilitants with major disability of speech or hearing.....	19,624	21,300	20,700	18,300
Deaf.....	6,728	7,600	7,300	6,300
Hard of Hearing.....	10,141	10,500	10,500	9,300
Speech.....	2,755	3,200	2,900	2,700

The effectiveness of casework rests in appreciable measure upon the joint planning of the counselor and the client. Clients who are hard of hearing or who have serious speech problems of other than hearing origin tax even the most skilled caseworker. Even so, counselor and client do have a line of verbal communication which encourages rapport. They can develop a good rehabilitation plan together. The profoundly deaf client, however, especially that large majority who have serious language deficiencies, are not able to communicate by normal means. This is the crux. There must be communication between counselor and client for effective casework.

The State agencies have recognized this basic factor and are moving to rectify it as qualified workers become available or through special training of current counselors. Fifty States 2/ now have or are actively recruiting staff who may be classified as expert vocational rehabilitation workers for the deaf since they are trained as professional counselors and are also able to communicate by sign language with deaf clients. Several of the States are searching for and others have already secured additional qualified counselors because their caseloads of deaf clients have rapidly grown beyond the capacities of the special staff as their deaf citizens have become aware that the vocational rehabilitation agency is now able to work more effectively with them. Forty-six States now have coordinators, too, to oversee and develop their vocational rehabilitation programs for the deaf and hearing impaired. The Rehabilitation Services Administration urges that each State have at least two highly skilled vocational rehabilitation counselors for the deaf and preferably that there be one in each metropolitan area.

1/ Data are actual for fiscal year 1973 and total of all rehabilitants for 1974. Estimates appearing in the President's budget are used for other data for 1974-1976 and will be updated at a later date.

2/ Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Guam, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Puerto Rico, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, and Wisconsin.

A continuing problem in the area of the hard of hearing through the years has been developing and maintaining adequate channels of referral of hard of hearing persons needing vocational rehabilitation services. Major efforts have focused on encouraging the professional, the medical, and the voluntary worker to refer persons with hearing impairment to State vocational rehabilitation agencies for evaluation and consideration of possible services. The results have been disappointing as witnessed by the relatively small number of hard of hearing clients rehabilitated each year as compared to the many thousands needing or able to benefit from our services. The persistence of this problem has encouraged us to look to other channels by which more persons may become knowledgeable of their entitlements under the vocational rehabilitation service. Accordingly, we have now established formal working relationships with the National Hearing Aid Society, a principal feature of which encourages referrals by hearing aid dealers of persons coming to their attention who may be eligible for the services of our State agencies. If this move is as effective as we expect, the number of hard of hearing rehabilitants each year should increase rapidly into the tens of thousands.

Service Centers

Most of the many hearing and speech centers that have been established in the past twenty years have come into being in universities as training and research facilities, in large hospitals as service units, and in metropolitan areas. They fill vital rehabilitation needs in diagnosis, in evaluation, in training, in lipreading, speech, and listening, and in selection of hearing aids. We may have as many as 900 centers of widely varying levels of effectiveness and uneven geographic distribution. Many thousands of people with communication problems are just too far away from even the least of these service centers and even further from the more technical assistance that they may need. For example, a hard of hearing person who is 50 miles away from lipreading instruction, auditory training, hearing aid evaluation, is not likely to be able to travel this distance several times per week for instruction and service. The Rehabilitation Services Administration is attacking this problem directly through encouragement of projects that bring the basic hearing and speech services that the majority of these disabled people need into the local community at a cost that it can afford to maintain, leaving for the more comprehensive center the intricate services needed by more difficult hearing or speech cases.

In this respect the State vocational rehabilitation agencies are making important contributions to the availability of hearing and speech evaluation services through grants to extend and improve vocational rehabilitation services for the communicatively impaired. In 1969 alone, ten State divisions of vocational rehabilitation established facilities or special programs to improve services to the communicatively impaired. Authorizations under Sections 2, 3, and 4(a)(2)(A) were used in the creation of 25 projects at a total cost of over one-half million dollars.

The practical needs of deaf people are little related to speech and hearing centers. Almost all of them have had several years of intensive, expert training in speech and use of residual sound perception in their special schools. The deaf need the same vocational rehabilitation services as other clients, specifically diagnosis, evaluation, training, counseling, and placement, but in language that they understand. There are very few persons in rehabilitation centers or vocational schools who can communicate with deaf people to the point where a good learning situation may be said to exist. Consequently, the Rehabilitation Services Administration has had to concentrate on developing centers where there are expert professional workers for the deaf. Usually, these have proven to be the residential schools for the deaf. Diagnostic, evaluation, prevocational, and adjustment centers have been established or are planned at the State schools for the deaf in twenty-seven 1/ States.

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Encouraging by-products of this activity are taking place in other States and there are growing efforts by established rehabilitation centers to qualify themselves to serve the deaf. Community service centers for deaf people, relieving residential schools for the deaf of counseling responsibility of deaf adults, are located in ten metropolitan areas and being planned in others.

Justification

The provision of specialized comprehensive rehabilitation services for a significant number of deaf people whose maximum vocational potential has not been reached continues to be a challenging and unmet need. These deaf people who have been estimated to number as many as 100,000 are severely limited in personal, social and vocational adjustment. Appropriate resources for them are just now beginning to be developed.

Rubella (German measles) epidemics in the 1960's have resulted in large numbers of deaf children having multiple disabilities. These rubella children have been swamping our schools for the deaf and will soon begin to present a new and demanding challenge to rehabilitation agencies.

Deaf persons whose maximum vocational potential has not been reached, who have not had the advantage of special training, have several characteristics which create difficulties for them in entering and holding gainful employment commensurate with their potentials. Some of these characteristics also account for their inability to qualify for existing post-secondary training programs for the deaf. Their problems cluster around vocational, rehabilitation, educational and social underachievement, severely limited skills in communication and adjustment to requirements of daily living and, in some, the presence of secondary physical disabilities.

The majority of these severely handicapped persons have normal strenth, intelligence and mobility. Recent research in providing vocational and adjustment training to deaf persons with serious personal, social and work adjustment problems has demonstrated that given proper assistance all of them can improve substantially in their ability to live independently and function more normally in their families and communities. This assistance needs to be provided on an intensive, long-term basis by staff who are able to communicate with them, possess a full understanding of their handicaps, and are skilled in the use of instructional techniques and tools for overcoming these handicaps.

The authorization in the Rehabilitation Act of 1973 for special projects and demonstrations to provide vocational rehabilitation service which hold promise of expanding or otherwise improving rehabilitation services to handicapped individuals (especially those with the most severe handicaps) including deaf individuals presents means for long-needed project development for severely handicapped deaf people. The projects will at long last make it possible to provide them with the special type of services they need to become employable or better employed.

1/ Alabama, Arizona, Arkansas, California, Colorado, Connecticut, Florida, Georgia, Illinois, Indiana, Louisiana, Maine, Mississippi, Missouri, Nebraska, New Hampshire, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, South Carolina, Tennessee, Texas, Vermont, and Wisconsin.

Of long concern to the Rehabilitation Services Administration has been the void in vocational training for deaf clients. The accelerating inroads of automation seem to have sharply reduced the number of entry level jobs by which the deaf have gained their footholds in industry. Consequently, more vocational training has been necessary for deaf people who frequently are poorly served or not at all by overcrowded vocational schools. This has intensified the training void for deaf people that exists between the special school system which generally terminates at 9th grade or less and Gallaudet College, a void which has nurtured and partially perpetuated their serious underemployment. Fortunately, the situation is changing for the better as programs are being developed to meet the various service needs of the deaf adult population.

Accomplishments

The establishment of the National Technical Institute for the Deaf authorized by Public Law 89-36 in 1968 was a very important step toward reducing the underemployment of deaf people. It is contributing vital new concepts in the training of deaf people and through its special job development and placement program opening employment that has not had many or even any deaf practitioners. The State vocational rehabilitation agencies are directly involved with every student.

Great strides are being made in vocational training for deaf people at existing community facilities. Demonstration programs at Delgado College, at Seattle Community College and at St. Paul Technical-Vocational Institute successfully integrated deaf students using support services such as interpreting, notetaking, tutoring and counseling. New and better employment opportunities opened to deaf people as they completed their training. The programs did much to stimulate interest at other schools in providing vocational training to deaf individuals. Currently, approximately fifty community colleges are sponsoring vocational training programs for deaf people modeled on the success of the three demonstration programs. The programs serve as vitally needed training resources for deaf clients of State vocational rehabilitation agencies.

A small but important beginning was made in 1974 in providing services to deaf people who have not achieved their maximum vocational potential. Three special projects funded by RSA were established in Indiana, Washington State and South Carolina to provide comprehensive rehabilitation services to severely handicapped deaf people for whom no programs previously existed. Two additional projects are expected to be set up in 1975 with others to come.

The Communicative Skills Program, a long-term training project funded by RSA now in its seventh year, continues its work to increase the number of rehabilitation personnel, professionals in allied fields and employers and co-workers of deaf people able to communicate with deaf persons in their sign language. Over sixty universities now offer credit courses in manual communication as a by product of the greater awareness and interest generated by the Communicative Skills Program.

The Registry of Interpreters for the Deaf, a former RSA project, is expanding and accelerating its certification program to meet the critical need of State vocational rehabilitation agencies for an adequate supply of certified interpreters to work with counselors serving deaf people.

The National Interpreter Training Consortium, a long-term training grant program funded in fiscal year 1974 by RSA involving six regional training programs, is expediting the development of certified interpreters needed by State vocational rehabilitation agencies. By 1979, it is expected that each State will have interpreter training programs easing our present acute shortage of qualified interpreters.

14 DEAFNESS Annual, a document reporting on research and training activities and trends in the area of deafness with a directory of programs and services for the deaf, is an indispensable tool to the State vocational rehabilitation agencies and to professionals serving deaf persons. The Professional Rehabilitation Workers with the Adult Deaf, which prepares and publishes the annual report, began this work as a RSA project.

Fifteen States 1/ have developed or are currently developing mental health programs for deaf people. The State of New York which absorbed the pioneering RSA supported demonstration mental health project for the deaf at the New York Psychiatric Institute provides the background for the developing programs. It is anticipated that additional States will commence this much needed work as more mental health workers who are able to communicate with deaf people become available.

1/ California, Connecticut, District of Columbia, Florida, Indiana, Illinois, Minnesota, New York, North Carolina, Ohio, Pennsylvania, South Carolina, Utah, Washington, Wisconsin.

Rehabilitation Services Administration Training Grants in Speech and Hearing (Speech Pathology and Audiology and Rehabilitation of the Deaf)

Rehabilitation Training

		1974 Actual	1975 Estimated	1976 Estimated
SPA and Deaf	Total	$191,894	$2,410,000	$1,850,000

Accomplishments

Training grants are available under the rehabilitation training program to support training in the areas of speech pathology and audiology and rehabilitation of the deaf. Since support of rehabilitation training was initiated in 1958, the number of training institutions has grown gradually and commitment of these institutions to train professionals in this specialty has been significant.

The focus in the Rehabilitation Act of 1973 on serving the severely disabled will impose new demands on the current available manpower providing services to a significant number of communicatively handicapped individuals in this country. Manpower will be needed to serve the deaf and the severely hearing impaired, the stroke patient with aphasia, and the laryngectomee population.

Special attention is being given under the rehabilitation training program to increasing the supply of qualified interpreters for the deaf.

Requirements in FY 1976

Training support in FY 1976 will continue to emphasize the training of skilled interpreters for the deaf to be available to assist State vocational rehabilitation agencies in providing services to severely disabled deaf individuals. Effort will also be made to improve the manual communication competence of students enrolled in training programs in established rehabilitation disciplines such as rehabilitation counseling and speech pathology and audiology.

Hearing and Speech

Recent review and analysis of available data indicate that the actual prevalence of speech, hearing, and language disorders in the United States is double previous estimates. Approximately 20,000,000 persons have communicative handicaps, with at least one-third of these suffering either substantial or severe social, education, and economic disadvantage. This relatively large portion of the handicapped population present a continued challenge to rehabilitation. Most communicative handicaps have their origin in childhood from varied causes, such as birth defect or injury, cultural deprivation, untreated disease, etc., but persist into adulthood. However, other causes occur in later life, such as problems of aphasia-related stroke, accidents, or brain injury, and problems of traumatic hearing loss due to excessive exposure to noise. Continued emphasis must be placed on the development of test instruments to assess the communicative behavior problems in order to facilitate rehabilitative and therapeutic goals.

Computer assisted instruction and programmed materials are being developed for clinical rehabilitation use of speech and hearing handicapped persons. The breakdown of communication barriers will allow for increased work potential and thus increased earnings for such individuals. There must be continued development of clinical procedures to assist aphasic patients, laryngectomies, and stutterers in social adjustment as the individual returns to his family and to the work community. Projects concerned with the rehabilitation of the hard-of-hearing, especially in culturally deprived populations and with the older American, will be encouraged. Greater emphasis must be placed on developing the full vocational potential of persons with varying degrees of speech, hearing, and language disorders.

Deaf

Problem areas for members of the deaf community have been found to include (1) basic language disorders underlying the communication handicap; (2) social and cultural deprivation; and (3) lack of awareness of the vocational opportunities which do exist. Our goals include the stimulation of projects concerned with basic rehabilitative procedures in language, with community efforts on behalf of the deaf, and with the expansion of vocational opportunities.

Projects concerned with expanding vocational and technical education opportunities, for deaf persons at the post-secondary education level, have been completed. Activities are now incorporated into regular service programs. There are projects in operation concerned with the development of mechanical aids to assist the teaching of language to the deaf. Several projects have begun which deal with the integration of deaf persons into the hearing community; projects concerned with providing mental health services; and projects involved in opening new job opportunities for the under-employed deaf. A major national census of the deaf has been completed and the report is available. A major thrust will be projects focusing on social interactivities of the deaf in hearing settings. Continued emphasis will be placed on the assessment of the potential of multi-purpose rehabilitation settings to serve the deaf community. An important area of focus will be on provision of improved services to severely disadvantaged deaf adults through facility demonstration including a free-standing residential facility. Development of telecommunications, including cable, and exploration of improved training techniques for deaf people are being thoroughly explored.

	1972	1973	1974	1975	1976
Rehabilitation Research and Demonstrations	$1,678,000	$1,000,000	$ 250,000	$ 180,000	$ 180,000

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REHABILITATION RESEARCH AND TRAINING CENTERS

Hearing and Speech

The New York University Deafness Rehabilitation Research and Training Center provides a continuing framework for research and training in the problems of communication as related to the disabilities associated with the totally deaf; conducts research and training in the evaluation and diagnosis, treatment, counseling, training, and placement of individuals with a wide range of speech and hearing disabilities in addition to their major rehabilitation specialities.

In Fiscal Year 1974, the New York University Deafness Research and Training Center and six other Research and Training Centers conducted a total of 40 speech and hearing related research projects in such areas as technological sensory aids for the deaf, speech therapy in aphasia, social interaction among aphasic individuals, evaluation of speech intelligibility of stroke patients, and input and output measures in aphasia.

In Fiscal Year 1974, the New York University Deafness Research and Training Center conducted 36 short and long-term training courses for 1,879 rehabilitation workers from all the disciplines involved in the rehabilitation of the deaf. Examples of such training include courses in Principles, Techniques and Problems of Psychological Counseling with Deaf Persons, Disturbances of Communication, Community Service Programs for Deaf Persons, Communicating with Deaf Persons, Psychology of Deafness, etc. In addition, most of the Research and Training Centers in Medical Rehabilitation offer both short and long term courses in Speech Pathology, Audiology, Communication Disorders, etc. All the 19 Reasearch and Training Centers have established close working relationships with the Regional Offices as well as with the State Vocational Rehabilitation Agencies, and they have addressed their needs in research and training as these pertain to the deaf population.

	1972	1973	1974	1975	1976
Research and Training Centers	$ 354,000	$ 400,000	$ 480,000	$ 500,000	$ 500,000

HEARING AND SPEECH

Obligations Fiscal Year 1972 to Fiscal Year 1976

Agency and Program	1972	1973	1974	1975	1976
OFFICE OF HUMAN DEVELOPMENT					
Rehabilitation Services Administration:					
Basic State grants...	$32,480,000	$34,751,000	$37,170,000	$39,440,000	$37,400,000
Innovation grants....	-	-	-	-	-
Service Projects.....	310,000	280,000	140,000	140,000	-
Rehabilitation training.....	832,540	3,767,067	270,800	270,800	1,150,000
Rehabilitation Research and demonstrations.....	1,678,000	1,000,000	250,000	180,000	180,000
Rehabilitation Research and training centers...	354,000	400,000	480,000	500,000	500,000
Special foreign currency program...	513,725	400,000	-	200,000	450,000
Total, RSA	$36,168,265	$40,598,067	$38,310,800	$40,730,800	$39,680,000

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HEARING AND SPEECH

Obligations Fiscal Year 1972 to Fiscal Year 1976

Agency and Program	1972	1973	1974	1975	1976
OFFICE OF EDUCATION:					
Elementary and secondary education...	$14,000,000	$19,800,000	$15,200,000	$15,800,000	$13,900,000 1/
Education for the handicapped.....	34,645,000	32,795,771	44,034,537	48,015,158	57,050,000
Occupational, vocational, and adult education.....	4,729,500	4,883,200	4,800,000	4,800,000	1,000,000 4/
Library resources....	40,000	50,000	40,000	40,000	30,000
Research and training.....	68,143	2/	---	---	---
National Advisory Committee on the Handicapped 3/.....	100,000	26,081	32,484	100,000	100,000
Subtotal, Office of Education.....	53,582,643	57,555,052	64,107,021	68,755,158	72,080,000

1/ The programs in these activities which supplied funds for hearing and speech are being consolidated, in fiscal year 1976, into a consolidated education grants program which specifies that 50% of the funds included in the consolidation must be used for the same purposes for which they were used previously. Beginning in 1977, total grant consolidation will be achieved.

NOTE: Of the activities reported from the Elementary and secondary education appropriation, Title I is not in the consolidation; Title III is.

2/ Program transferred to the National Institute of Education in fiscal year 1973.

3/ From 1972-1973, amounts are for the National Advisory Committee on Education of the Deaf; during 1974 this Committee combined functions with the National Advisory Committee on Handicapped Children to form a new National Advisory Committee on the Handicapped. This activity was previously reported under the Office of the Secretary.

4/ New legislation will be proposed for most of the programs involved. No estimates can be included for those activities.

Office of Education

Programs for the Speech and Hearing Impaired

According to the most recent estimates of the American Speech and Hearing Association, speech and hearing disorders account for about 21.0 million handicapped individuals. Of this number approximately 3.0 million possess learning difficulties severe enough to interfere with communication and the development of normal speech and language. Six hundred thirteen thousand are totally deaf, and thereby incapable of understanding speech through the auditory mechanism. About 5 million represent children and adults with significant speech and language difficulties generally unrelated or only in part related to learning disorders. Among the types of speech and language problems found are those related to stuttering, aphasia, articulation and voice disorders, and developmental language disorders. These problems may be related to other handicaps such as cerebral palsy, mental retardation, learning disabilities, larynxectomy, and emotional disturbance.

The Office of Education has expanded significantly its activities related to improving and enlarging educational opportunities for hearing, speech, and language handicapped children in the past several years. In fiscal year 1975, 49,340 children with speech and/or hearing handicaps were provided with services at the preschool, elementary, and secondary school levels. In the same year, 23,380 children with hearing problems were served in State-operated or State-supported schools.

Elementary and Secondary Education

Title I

The purpose of the P.L. 89-313 Amendment to Title I, Section 121, P.L. 93-380, is to provide assistance to the States for the education of handicapped children in State-operated and State supported schools. A new provision, beginning in fiscal year 1975, requires that if a child is transferred from a State-operated or supported program to one operated or supported by a local school system that the P.L. 89-313 funds follow him there.

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 and/or multi-handicapped. Model and pilot programs for these types of children have been conducted under P.L. 89-313 in many States.

During fiscal year 1973 about $76,000,000 was appropriated to serve handicapped children in this program. Of this amount about $11,000,000 was expended for children with hearing problems and about $5,000,000 was expended for speech services. During fiscal year 1974, 22,166 children with speech and hearing defects were served through expenditures of about $11,400,000. In fiscal year 1975 we hope to serve over 23,380 children with about $12,000,000 and in fiscal year 1976, with a about $12,000,000 we hope to serve the same number of hearing and speech impaired children.

Title III

Title III of the Elementary and Secondary Education Act (P.L. 89-10) provides non-matching grants to local education agencies to stimulate and assist in (a) the provision of vitally needed educational services not available in sufficient quantity or quality, and (b) the development and establishment of exemplary educational

programs to serve as models for regular school programs. This program gives special consideration to projects that are truly innovative as well as being of high quality and responsive to local needs. At least fifteen percent (15) of the grant funds are to be devoted to programs for education of handicapped children.

In Title III the majority of special education projects involve some type of speech and hearing component for the children being served. In 1973, two of the 197 validated projects were in the area of speech and one of the 84 validated in 1974.

In fiscal year 1976, Federal support for Title III will be included in a new consolidated education grant legislative program, which requires that 50% of the funds be used for activities previously supported. In 1977, this requirement is eliminated. An estimated $3,800,000 has been used for hearing and speech activities each year, until fiscal year 1976, when the amount estimated is reduced by 50% to $1,900,000.

Education for the Handicapped

The Bureau of Education for the Handicapped (BEH) is administratively organized into four major divisions under the Office of the Deputy Commissioner. Each of the major divisions -- Personnel Preparation, Assistance to States, Media Services, and Innovation and Development -- functions as integral elements in the total BEH program for handicapped children. The following pages describe the functioning of each division as it relates specifically to the speech and hearing impaired.

Division of Assistance to States

Under this division, there are two branches. One administers the Aid to States program, and the second runs the severely handicapped programs, which includes the Deaf-Blind Program.

Aid to States Branch

A. Branch purpose.

The Aid to States Branch is responsible for administering and monitoring programs of assistance and also providing technical and developmental assistance to States in the design, development, implementation and review of State plans for the education of the handicapped. The Branch also serves as a clearinghouse of information concerning novel and/or effective approaches to special education in other States.

B. Historical Development.

The purpose of Title VI, Part B, Education of the Handicapped Amendments of 1974, P.L. 93-380, is to provide funds for the States for the initiation, expansion and improvement of special education and related services for handicapped children at the preschool, elementary, and secondary school levels; and may be used for the early identification and assessment of handicapping conditions in children under three years of age. Beginning in fiscal year 1975, the State plan must include a goal of providing full educational opportunities to all handicapped children and provide a procedure to assure the accomplishment of this goal, with priority expenditure of funds going to serve children who are not receiving an education. The State plan must also provide for procedural safeguards concerning the identification, evaluation and educational placement of the children.

Part B funds are viewed as being used to produce a catalytic effect in the States, as opposed to providing continuous basic support services.[21] Projects under Part B include such items as diagnostic services, curriculum development, instructional materials, equipment, leadership activities, in-service staff training, etc.

C. Impact on Speech and Hearing.

During fiscal year 1973, about $37,500,000 was obligated for the Part B program. Of this amount $8,000,000 was expended on behalf of speech and hearing handicapped children. In fiscal year 1974 , a total of 49,340 children with speech and/or hearing handicaps were served with $8,800,000 of a total Part B appropriation of $47,500,000. Of the $100,000,000 appropriated for each of the fiscal years 1975 and 1976 $14,300,000 will provide hearing and speech services for 80,000 children in each year.

Special Services Branch - Programs for the Severely Handicapped

A. Purpose.

The Special Services Branch, of the Division of Assistance to States monitors two special programs directing attention to severely handicapped children and youth. "Telecommunications for Severely Handicapped Children and Youth who are Homebound," was designed to explore the effectiveness of modern telecommunications technology in the provision of educational/training services to those severely handicapped children and youth who are homebound due to restricted mobility or to other aspects of social performance of physical involvement. "Programs for Severely Handicapped Children and Youth provides for the funding of projects which would provide in conjunction with relevant public and private agencies and organizations within a State, (a) a plan for comprehensive services designed to meet identified, developmental needs of severely handicapped children and youth; (b) a model, demonstration program providing direct educational and/or training services for these children and youth which can ultimately be replicated State-wide and throughout the nation; and (c) a dissemination strategy whereby information about exemplary program activities or elements will be made widely known to both professional and nonprofessional personnel working with or interested in the education/training of severely handicapped children and youth.

B. Assessment Needs.

It is estimated that nearly one million severely handicapped children and youth are totally excluded from the educational system of our nation. At least 300,000 others are not receiving adequate services.

The principal problems delimiting the delivery of effective educational/training services to severely handicapped children and youth, in those areas where such services are mandated or supported, include: (1) extensive deficiencies in personnel with expertise and experience; (2) lack of adequate, functional facilities; (3) general void of appropriate curricula, methodologies, and education/training programs; (4) scarcity of specialized materials and equipment; (5) limited child and youth identification; diagnostic, prescriptive, and placement services; and (6) a general apathy or lack of concern for the needs of such persons, as well as the near nonexistence of advocate groups organized and functioning on their behalf.

The extreme shortage of adequate facilities, staff, and programs, has in many instances limited placement options for severely handicapped children and youth to already overpopulated institutions where, with a lack of funds, facilities, and staff, it has been impossible to provide little more than custodial care. Under more fortunate circumstances there may be more appropriate

programs as institutions, and a variety of education/training service capabilities in home communities through mental health clinics, group home, halfway houses, and interim care placement centers. The States of Washington and New York are among those implementing some of these techniques. The "Rosenberg Report," a study in New York State in 1969, found that almost one-third of the retarded children and adults institutionalized by the State could be placed in the community if there were appropriate mental health and day-school facilities for them. At the present time, adequate facilities for such placements are very limited.

Among the most isolated of all severely handicapped children are those who reside in the nation's "training schools for the retarded and mental hospitals for the emotionally disturbed." Many of these institutions are located far away from the developed community; often those in larger cities are in relatively isolated or inconvenient locations. Children in these institutions rarely leave the grounds of the facility and are almost never given the opportunity to participate in the educational programs of the local school district.

C. Current Activities 23

The Special Services Branch funded ten (10) programs and five (5) telecommunication programs in fiscal year 1974. The ten programs, totaling $2,246,659, will be set up as model demonstration programs to be replicated throughout the States. The five telecommunication efforts, totaling $1,557,477, deal with Telecommunications for Severely Handicapped Children and Youth Who are Homebound. Telecommunications can be a link between severely handicapped children and the improvement of their social skills and enrichment of their general life situation. The following is a brief synopsis of "Telecommunications and Programs for Severely Handicapped Children and Youth."

Historical Overview and Future Goals

Through activities addressed to the needs of the severely handicapped, we will undertake cooperative planning with related Federal agencies and with State departments of special education to target resources at this population. There will be a program of technical assistance to State education agencies to improve both their management and planning techniques so as to make maximum use of all Federal resources that can be dedicated to the needs of the severely handicapped.

Since 1969, the Bureau has held planning workshops aimed generally at developing States' capacity to plan and prioritize for themselves. In the Spring of 1971, OE/BEH objectives for handicapped children were established to dramatize learning needs of severely handicapped children.

The specific strategy proposed for implementation by BEH during fiscal year 1975 as an initial thrust toward meeting the educational/training needs of severely handicapped children and youth is: To develop and refine a national compact between the Office of Education and selected States on the education and training for the severely handicapped. A tentative plan for such an agreement has been drafted to incorporate the major service delivery problems that will have to be considered, resolved and funded from both State and Federal sources. The objective of this year's activity is to engage in a dialog with these States to determine the feasibility and possible deficiencies of the task required to launch the implementation stage of such a national plan. In furtherance of the intent of this year's activity, it is visualized that we would pursue this effort along two lines: (a) technical assistance to the several States to explore various areas of mutual concern, and (b) the development of benchmark data to be used in a preliminary assessment of the scope and quality of the plan.

E. Impact on the Speech and Hearing Impaired

The following statistical analysis denotes the current participants in "Programs and Telecommunications for Severely Handicapped Children and Youth." As it reflects in the data presented, 28% were considered to be multi-handicapped. This category included children with speech and hearing deficiencies. In terms of money expended, the percent reflects approximately $1,065,158 on behalf of the multi-handicapped, which includes speech and hearing impairments.

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Centers and Services for Deaf-Blind Children

A. Program purpose

The purpose of this program is to "provide through a limited number of model centers for deaf-blind children, a program designed to develop and bring to bear upon such children, beginning as early as feasible in life, those specialized, intensive professional and allied services, methods, and aids that are found to be most effective to enable them to achieve their full potential for communication with and adjustment to, the world around them, for useful and meaningful participation in society and for self fulfillment."

These centers will develop and provide services to children who are deaf-blind and have been deprived of their major avenues of learning and contact with the every-day experiences of life.

B. Historical Background, Legislation and Funding

Public Law 90-247 was passed in response to the rubella epidemic (German measles) that swept the nation and left many children with auditory and visual impairments, as well as other handicapping conditions including mental retardation. Approximately 5064 children were left deaf and blind. There were no programs in existence for such children at that time. In 1969, the first eight regional deaf-blind centers were started. In 1975, we have a total of 10 Regional Deaf-Blind Centers serving deaf-blind children in all 50 States and U.S. Territories.

Total funding approved for Centers and Services for Deaf-Blind Children, by school year, is as follows:

1969-70	$ 1,000,000
1970-71	2,000,000
1971-72	4,500,000
1972-73	7,500,000
1973-74	10,000,000
1974-75	14,055,000
1975-76	12,000,000
1976-77	16,000,000

3832 deaf-blind children are in various types of educational programs located in public and private institutions and state hospitals for the mentally retarded. Some of the types of services offered by the Deaf-Blind Program are as follows:

1. Full and part-time education services (both residential and day)
2. Diagnosis and Evaluation
3. Parent Counseling
4. In-Service Training
5. Short term programs (summer school, respite care)
6. Pre-vocational programs

C. Impact on Speech and Hearing

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By definition, all of these children have speech and hearing problems. Therefore, 100% of our children being served have speech and hearing problems and are receiving appropriate services in this area.

Division of Media Services

Under the Division of Media Services, there are three major activities: the Media services and captioned films, Recruitment and information, and Regional resource centers. Of these three programs, only the media services and captioned films program directly impacts, in a definable way, on the hearing and speech-impaired. While efforts in the other two programs are not targeted on any individual handicapping condition, they do have an impact on these people.

Media Services and Captioned Films

A. Program Purpose

This program, authorized under Part F of the Education of the Handicapped Act provides the handicapped learner with specific educational materials directed at educational needs. This purpose is being advanced through the operation of a National Center for Educational Media and Materials for the Handicapped and a network of Area Learning Resource Centers which focus on the development and dissemination of materials and media for the education of the handicapped. Another major purpose is the captioning and distributing of motion picture films and other media to the deaf and hearing impaired population.

B. Historical Development

During 1973 and 1974, more than 3,680 groups of hearing impaired persons, representing an audience of 2.85 million people, were reached through the Media Services and Captioned Film program. Of these, 1,320 were schools or classes for the deaf. The total audience for theatrical films numbered over 1.5 million with a monthly average of 3,200 showings.

The program circulated more than 600 different captioned educational films through its 60 film depositories.

In 1975 the number of groups of hearing impaired persons reached will exceed 3,900 (1,400 schools and classes for the deaf). The captioned theatrical and cultural films will reach a total audience of 13 million persons with a monthly average of 4,220 showings.

700 captioned educational film titles will reach an audience of 1.6 million hearing impaired children, with classroom showings averaging over 10,500 per month.

Support of the National Theatre for the Deaf is continuing, and a daily captioned evening news broadcast over the national PBS network was continued. Experiments to develop an electronic coding system to provide captioned television programming to a potential audience of more than 13 million hearing impaired Americans are continuing.

The National Center on Educational Media and Materials for the Handicapped is conducting a needs assessment of specific requirements and standards for media and materials for handicapped children. The network of 13 Area Learning Resource Centers and 4 special category centers is providing a national delivery system of educational media to handicapped children.

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C. Impact on Speech and Hearing Handicapped

The speech and hearing handicapped population of this country has been and continues to be one of the principal beneficiaries of this program. Over 3,900 groups of hearing impaired persons participate in the media services and captioned films program. Captioned theatrical and cultural films reach over 1.3 million persons. The captioned newscast on PBS television is a daily occurrence and the support of the National Theatre of the Deaf allows it to play a major role in the cultural, educational, and vocational betterment of the deaf. Obligations in the program are as follows:

1973	$12,767,000
1974	13,106,000
1975	13,000,000
1976	16,000,000

Division of Personnel Development

Special education manpower development for fiscal year 1973, approximately $4,000,000 was obligated for awards for speech and hearing. We anticipate the same amount will be obligated in fiscal year 1974, 1975 and 1976. The Division of Personnel Preparation has moved completely to Program Assistance Grants. While our expectations are that the number of treinees directly supported will rise slightly, we do not delineate all trainees according to distinct handicaps.

In addition, the State Educational agencies expended approximately $500,000, mainly through special study institutes and summer session traineeships in order to upgrade and update the skills and knowledge of inservice speech and hearing personnel.

Although the school-age population of deaf children has remained relatively constant in the past few years, the downward extension of educational services to very young preschoolers has increased the total number. It is estimated that there are over 50,000 deaf pupils in the United States. Due to a shortage of teachers and other obstacles, an additional 14 percent are not receiving the specialized help necessary from schools and classes appropriately equipped to serve these children.

Division of Innovation and Development

A. Early childhood education

Part C of the Education of the Handicapped Act enables the Commissioner of Education to make grants or contracts to public and private non-profit agencies for the development and implementation of model and demonstration programs. These grants are distributed on a broad geographical basis throughout the nation.

The goal of this program is to demonstrate a variety of approaches for providing services to young handicapped children and their families. The projects are intended to serve as models for agencies wishing to replicate project or its components.

Parent/family participation is an important part of each project's activities. Assessment of child progress, inservice training, coordination with the public school and other agencies, and evaluation are other components.

After the three-year period of Federal support for demonstration those projects which have obtained funding from state, local or other sources to continue the basic service component become eligible to apply for funding to carry out outreach activities designed to enable other agencies to provide services for young children with handicaps. Many of the projects are involved in providing training or resource assistance to Head Start projects which wish to enroll children who have handicaps.

The Act provides for a Federal share of up to 90 percent of the cost of a project. During 1972-73, the entire early education program, which serves all types of young handicapped children, including 71 local activities and was

funded at 7 million dollars. In fiscal year 1973, total obligations for the program were $13,325,000; in fiscal 1974, $16,151,000, in fiscal year 1975, $14,000,000, and fiscal year 1976, an estimated $22,000,000. Of the total program the portion estimated to be devoted to hearing, speech, and language development is about 20%; in fiscal year 1973, $2,665,000; in fiscal year 1974, $3,230,000; in fiscal year 1975, $2,800,000, and in fiscal year 1976, $4,400,000.

B. Research and demonstration

a. Purpose

This program 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, development and media activities.

b. History

This program, administered by the Research Projects Branch, was initiated during fiscal year 1964 with an appropriation of one million dollars authorized under Title II, Section 302 of P.L. 88-164. Through the ensuing years the authorization has been continued, and the scope and flexibility of the program have been expanded. In April, 1970, the various acts of legislation that pertained to research were incorporated into P.L. 91-230, Education of the Handicapped Act. The latest act, P.L. 93-380, provided for authorizations of appropriations through fiscal year 1977.

The following table provides data on the number of projects and amount of support specifically related to the education of speech and hearing impaired children.

Division of Innovation & Development
Projects Research Branch
Projects on Speach and Hearing

Year	Number	Amount
1964	9	$ 184,691
1965	12	307,032
1966	31	1,019,470
1967	38	1,710,970
1968	34	2,205,722
1969	34	1,608,517
1970	21	1,976,327
1971	19	1,825,406
1972	11	1,742,489
1973	10	1,630,771
1974	18	843,537
1975	18	850,000
1976	20	850,000

In addition to these projects, an increasing proportion of research funds have been allocated to projects which impact more generally on the education of handicapped children. In general, such "non-categorical" projects have tended to equal or exceed the amount of activity directed specifically at the field of speech and hearing, and may be assumed to have virtually as much an impact on programming in the field as do those projects which relate to problems specific to the speech and hearing impaired.

C. Impact on Speech and Hearing Disabilities

It is often difficult to assess the direct impact of research activities on educational programming since the lag between the discovery of new knowledge and consequent changes in educational practices obscures the relationship. However, a number of suggestions regarding program impact are available. As of the end of fiscal year 1974, supported projects had resulted in the distribution of over 500 projects reports relating to education of the handicapped through the ERIC system, and at least an equal number of publications in referred professional journals. In addition, validated curriculum materials designed specifically for the speech and hearing impaired have been developed and are now available in the areas of articulation therapy, language for the deaf, and control of stuttering. Special education instructional materials center and regional resource centers for the handicapped which began as development/demonstration projects supported through the research program have now become institutionalized service operations providing services to the speech and hearing impaired as well as other handicapped populations.

D. Current Activities

Current project efforts supported by the Research Projects Branch are involved primarily with the development and validation of more effective and efficient methods for correcting disabilities in the area of articulation, particularly program instruction and automated systems, delivery systems for speech and hearing services; and language development of deaf children.

E. Future Goals

A substantial portion of the activities currently supported by the Research Projects Branch are designed to further specify future plans and programs in the support of educational research relating to the handicapped. The initial stages of this planning effort suggest strongly that efforts in the area of speech will continue to be addressed primarily to improvement in delivery systems for speech therapy services in the public schools and that efforts relating to the hearing impaired may focus strongly on language and speech development activities. However, it would be premature to suggest specific goals in view of the heavy current investment in projects which are designed to lead towards planning decisions.

Vocational Education

At least ten percent of the basic grant funds under the Vocational Education Amendments of 1968 are mandated to be spent on the handicapped. This category includes those who are hard of hearing, deaf, or speech impaired. From the descriptive reports of the States which are submitted annually, there are a number of programs in which these particular handicapped students are being served.

Illustrations of the kinds of programs carried on in some States are: pre-employment vocational experience programs; vocational printing; office occupation programs for the deaf; pre- and post-testing of occupational aptitudes; utilization of teacher and instructional aides to provide individualized instructions; work adjustment.

Vocational Education reporting system does not collect data for each category of the handicapped.

Estimated enrollments for fiscal year 1973 include 1,000 deaf persons, 5,000 hard of hearing and 15,000 speech impaired. It is estimated the same level of support will be maintained in fiscal year 1974.

Funds provided have been: fiscal year 1971, $3,387,200; fiscal year 1972, $3,790,000; fiscal year 1973, $3,790,000; fiscal year 1974 estimate, $3,800,000; and fiscal year 1975 estimate, $3,800,000.

Approximately 10% of the funds provided can be identified as having been expended to provide specific programs and services for the deaf, hard of hearing, and/or speech impaired.

Beginning in fiscal year 1976, all funds under the basic grant program will be requested under newly proposed legislation. No funding has been requested yet, nor do we know the effect on the hearing and speech impaired.

Adult Education

Adults with speech or hearing impairments who have not attained the equivalent of a high school education are eligible to attend adult education programs. It is estimated that approximately 2% of the total effort in State grant funds are used for educational programs designed specifically for under-educated adults with such impairments. In fiscal years 1974 through 1976 it is estimated the same level of support will continue.

It is anticipated that additional emphasis will be given to the staff development needs of supervisors, teachers and para-professionals working with adults who have hearing impairments. The fact that the Education Amendments of 1974 consolidated the national teacher training and special project resources into the State Grant will enable the State agencies to earmark more resources for the handicapped.

Library Resources

Through fiscal year 1971, funds under Title IV-A of the Library Services Constriction Act were for the purpose of establishing and improving State-supported institutional library services. Residential schools for the handicapped, including hard of hearing, deaf, and speech impaired, may be included in a State plan if these schools are operated or substantially supported by the State. Funds may be used for providing books and other library materials as well as other library services to students in such residential schools under an approved State

plan. In fiscal year 1974, 23 State institutions for the deaf and/or State-supported institutions for the deaf and blind benefitted through the efforts of this program.

A typical community project is included:

District of Columbia

For persons who are deaf and for those who have hearing impairments, the D.C. Public Library initiated a first-time public information teletype service on December 2, 1974. More than 800 deaf persons in the metropolitan area already own teletype machines with special adapters for their telephone and will be able to call the D.C.P.L. telephone reference service and receive by teletype any information available at the Library. Staff members are learning signing in the Library, in order to better serve this special group of users. One librarian uses signing and miming in telling stories to children with hearing impairments in institutions and libraries; LSCA has financed her training at Gallaudet College.

Beginning in fiscal year 1972, the Library Services and Construction Act, as amended, continued library services to State institutionalized persons and physically handicapped persons under Title I. Programs for those persons are being maintained at a minimal of the 1971 level through 1976; however, the majority of the programs have been increased with State dollars.

National Advisory Committee on the Handicapped

The National Advisory Committee on the Handicapped is composed of special educators, persons interested in education and welfare of the handicapped, and regular educators. The Advisory Committee is required by law to carry out the following functions: (1) make recommendations to the Secretary for the development of a system for gathering information on a periodic basis in order to facilitate the assessment of progress and identification of problems in special education; (2) identify emerging needs respecting special education and suggest innovations which give promise of meeting such needs and of otherwise improving the educational prospects of handicapped individuals; and (3) suggest promising areas of inquiry to give direction to the research efforts of the Federal Government in improving the education of the handicapped. In fiscal year 1974 the National Advisory Committee on Education of the Deaf and the National Advisory Committee on Handicapped Children combined functions to form the new National Advisory Committee on the Handicapped.

The obligations for fiscal years 1972-1976 are as follows:

	1972 Actual	1973 Actual	1974 Actual	1975 Estimate	1976 Estimate
Salaries and Expenses	$100,000 1/	$26,081 1/	$32,484	$100,000	$100,000

1/ For the National Advisory Committee on the Education of the Deaf.

HEALTH SERVICES ADMINISTRATION
BUREAU OF COMMUNITY HEALTH SERVICE
Hearing, Speech and Language Disorders 1/

	Actual Obligations 2/			Estimated Obligations 2/	
	1972	1973	1974	1975	1976
Special Projects.....	930,000	930,000	700,000	700,000	700,000
Children and Youth Projects.....	745,000	745,000	760,000	2/	2/
University-Affiliated MR Centers.....	1,070,000	1,000,000	1,100,000	1,100,000	1,100,000
Subtotal.....	2,745,000	2,675,000	2,560,000	1,800,000	1,800,000
Research					
Direct Impact.....	320,000	303,500	186,000	186,000	186,000
Indirect Impact.....	---	895,000	624,000	624,000	624,000
Special Foreign Currency Program.....	90,000	97,000	100,000	100,000	100,000
Total.....	3,155,000	3,970,500	3,270,000	2,710,000	2,710,000

1/ Report represents the activities under Title V, Social Security Act (Maternal and Child Health Service Programs).

2/ Excludes formula grant funds expended by States for hearing and speech activities, for which no estimate is available.

HEALTH SERVICE ADMINISTRATION 33

Bureau of Community Health Services

Hearing, Speech and Language Disorders Program

(Title V, Social Security Act, Maternal and Child Health)

The Bureau of Community Health Services, Health Services Administration, administers funds appropriated under Title V of the Social Security Act for Maternal and Child Health and Crippled Children's Services. These funds are available as formula grants to State Maternal and Child Health and Crippled Children's agencies, to meet the requirements of Title V including the requirements for projects for the comprehensive health care of children and youth, maternity and infant care, dental health care, training of professional personnel and for research related to the health of mothers and children.

The Bureau of Community Health Services assists state and community health agencies in planning, developing and evaluating programs of health services for children including those with communicative disorders of speech, hearing and language. These efforts consist of (1) providing technical assistance by staff which is consonant with the national goals and objectives of the HSA and BCHS (2) initiating, conducting and supporting efforts by grants and contracts to improve speech and hearing services and the related delivery system (3) issuing program guidelines and other material relevant to the needs of professionals and parents (4) reviewing the performance of programs and initiating studies which focus on improving the quality of services, the extension of services, and the training of personnel, as related to the development and disorders of speech, hearing and language.

The data in the table accompanying this report represent the obligations and expenditures for speech and hearing services which have been included in the different categories of project grants. The amounts expended by the States for speech and hearing services under the Title V formula grants have not been reported by the States thus, the total national cost of the program for speech and hearing is not identified.

The Problem

Of the 83.8 million children under 21 years of age in the United States in 1970, there were 9 million who were handicapped according to estimates prepared by the Rand Corporation for the Secretary of the Department of Health, Education and Welfare (R-1420-HEW, May 1974, p.3). Among these there are 2.7 million with hearing and speech impairments. These estimates of the prevalence clearly indicate that communication disorders are of a magnitude that a significant effort is required in the prevention, detection and treatment of the problems. There are almost a half million children and youth who are hard of hearing or profoundly deaf.

Studies have shown that if the hearing loss exists from birth or early years, the child must receive early rehabilitation and training if the handicap in communication is to be prevented or effectively managed. The fact is that for many children the treatment programs have often been delayed until the school years. Recent legislation in many states to require educational services for handicapped children at preschool ages is a compelling reason for health agencies to increase their efforts to find and diagnose children whose handicaps may include communication disorders.

The etiologies of hearing impairment can be roughly divided into two categories which are susceptible to preventive actions, early detection and early and comprehensive treatment. One category includes those conditions related to maternal health, the course of the pregnancy, the delivery and aftercare. This category requires the provision of comprehensive health services for the mother and newborn. It includes the provision of the Rh anti-immune vaccine and the rubella vaccine as well as other efforts to prevent diseases which affect the sensorineural system. The other category includes those hearing problems related to malformations, disease and dysfunctions of the upper respiratory system, particularly the middle ear. This category requires that the detection of the hearing problem be accomplished as early as possible to avoid further medical complications and the effect of deprivation of auditory stimuli. Accurate diagnoses must be made promptly so that treatment can be planned which is appropriate and most likely to help the child.

Speech and language problems are caused also by conditions other than hearing impairment, and are frequently the reason parents seek health services. A wide range of problems, including multiple handicaps, may so seriously interfere with the child's communicative skills that he is handicapped educationally, socially and vocationally. While treatment and training is often directed solely at the child's speech and language impairments, there has been increasing attempts to use the efforts of multiple disciplines thus avoiding some of the fragmentation of services. To meet this need for team oriented clinicians a further development of interdisciplinary training programs and further refinement of standards of quality of care is required.

The problem of increasing the effectiveness of care while at the same time reducing its cost requires that one of the program objectives must be to improve the continuity of services. The treatment program for communicative disorders requires coordination between the health service specialists and the school clinicians, and between clinical services and the home. For such continuity to be established and improved, there must be an improved coordination among the programs for speech pathology and audiology services at all levels of the government.

Goals

The BCHS program for speech and hearing services under Title V, Social Security Act, is guided by the following goals:

1. To assist State and community health agencies to develop additional programs and to extend present programs, especially to infancy and early childhood, for the prevention, identification, diagnosis and treatment of communicative disorders of hearing, speech and language.

2. To develop and improve, with technical and financial assistance, the quality of the personnel and facilities available to serve children with hearing , speech and language disorders.

3. To identify problems related to providing or improving specialized services and to develop and support studies pertaining to these problems in serving children with communicative handicaps.

State Agency Programs

The services provided in a hearing and speech program in a State Maternal and Child Health or Crippled Children's Service program include medical and surgical treatment, hospitalization and aftercare, audiology and speech pathology services, nursing, social work and psychology services and other health services as required, including the provision of hearing aids. While services for hearing and speech impairments are provided in each of the States, the nature and scope of these services vary among the States and among communities within the States.

Some of the activities related to a hearing and speech program are basic activities related to overall preventive health services and general health care provided to children. For example, the program for immunization is significant in the prevention of disease leading to sensorineural hearing impairments. Similarly, medical treatment of upper respiratory infections, and acute otitis media is a significant part of preventing conductive hearing impairments. The health services required for an effective hearing, speech and language program include a wide range of disciplines involved in casefinding, assessment, medical and non-medical treatment and therapy, counselling and habilitation.

In all but ten states, either the Maternal and Child Health agency or the Crippled Children's Service agency, or both, employ professionally qualified speech pathologists or audiologists to be responsible for the development and implementation of a program for hearing and speech services. Speech and hearing programs in State Maternal and Child Health and Crippled Children's Services Agencies provide services both directly and indirectly in a variety of different delivery systems.

Casefinding, preventive and diagnostic services, in many states are provided directly by State personnel at both the professional and supportive personnel levels. Treatment services for both hearing and speech impairments in some States are provided by state employed staff, but most often are purchased from existing hearing and speech facilities and from professional personnel in hospitals, rehabilitation centers and other facilities. Speech services usually are provided as an integral part of the services for children with other handicapping conditions, including mental retardation, cerebral palsy and cleft palate. For fiscal 1973, the hearing of more than six million children was tested. The number of children who are found by these hearing tests to need medical and other help is, on a national average, approximately 2% to 3% of the total. This national average, however, fails to emphasize the fact that in some geographic areas the prevalence of significant hearing impairment is 15% and in Alaska, for instance, it is above 30%. The number of persons who are profoundly deaf from birth is approximately two per thousand in the general population. In fiscal 1973, the total number of children with cerebral palsy served by the Crippled Children's Service was more than 42,000 and those with cleft lip and palate were more than 25,000. The Crippled Children's Service reported providing services to more than 62,000 children with hearing impairments; of these more than 24,000 were serviced for the first time in fiscal 1973.

Bureau of Community Health Services Program

Technical assistance by professionally qualified specialists is provided to State health departments and crippled children's services and to other grantees receiving funds under Title V, Social Security Act, as well as to appropriate voluntary and professional organizations. Financial assistance is provided through grants and contracts for special projects in the area of speech and hearing which are of regional or national significance.

Hearing and speech services are an integral part of Title V project grants for comprehensive health services for children and youth who live in poverty areas. The projects provide screening, diagnostic, preventive, corrective and followup services for children of families who live in low income areas. About 75 hearing and speech specialists are employed as staff in these projects to provide speech pathology and audiology services.

Special projects specifically concerned with hearing and speech services include grants to the Colorado State Department of Health for demonstrations related to communicative disorders; the Iowa Crippled Children's Service to explore developments in providing hearing and speech services to mentally retarded children; the Alaska Department of Health to develop a joint program of audiology services with the Alaska Native Health Service.

Special training projects in speech pathology and audiology continue to receive grant support at the Johns Hopkins University, University of Iowa, University of Oklahoma Medical School, the New York University Medical School, and Vanderbilt University Medical School. The project at Vanderbilt University includes a cooperative

training program with Tennessee State University, a historically black institution of higher education. This project, along with one to be implemented at Howard University is developing new patterns of professional preparation for speech pathologists and audiologists to serve children whose cultural and linguistic backgrounds are different from that of the speech and hearing specialist.

In addition training for speech pathologists and audiologists is included as one of the more than fifteen health professions which receive support for training in the University Affiliated Training Centers. The purpose of this training is to increase the effectiveness and quality of interdisciplinary and multidisciplinary care to handicapped children.

Grant support has been continued for research studies related to the service needs of programs supported by Title V funds. A study of computerized audiometry, utilizing the responses evoked by electroencephalography completed at the Albert Einstein College of Medicine will aid in developing more effective diagnostic tests. A study recently completed at the University of Hartford, is concerned with developing automated procedures for evaluating of the language functions in infants and young children with severe auditory impairments. The Langley Porter Neuropsychiatric Institute is conducting a study to describe the development of parent-child communication in families with a child who is deaf. A study of the auditory and visual perceptual deficits related to neonatal jaundice is being carried out at the Pennsylvania Hospital in Philadelphia. The New York University study of the behavior of school age rubella children is yielding important insights with respect to their hearing impairment.

Continuing activities in research under the International program include studies of the methods for the early detection of hearing loss. Such studies have been supported with special currency funds in Israel, Poland and are being continued in Yugoslavia. A project in Egypt has as its purpose the development of a hospital-based model for delivering speech and hearing services.

Planning

An objective of the speech and hearing program has been to aid the profession to function effectively in whatever health delivery system is finally evolved. National conferences of leaders in public health, of directors of speech and hearing clinical services, of directors of training in speech pathology and audiology were held over the past three years to implement this objective. As a result, the profession itself has conducted Regional and State meetings and additional meetings will be held in 1975 with the assistance of the BCHS staff. These meetings will include a national conference of speech pathologists and audiologists in Children's Hospitals to consider issues related to the assessment and assurance of the quality of services in the present hospital speech and hearing centers.

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The effort to encourage speech pathologists and audiologists to become knowledgeable in comprehensive planning for health service will be continued. The end result expected is a decrease in the likelihood of fragmentation and overlapping of services and the inefficient use of community resources.

A long term objective of improving the evaluation of the effectiveness of speech and hearing services is being continued in a joint effort between BCHS staff and the Minnesota Systems Research Inc. This effort has refined operational definitions and developed a coding system for data collection and analysis related to the projects for health services to children and youth.

Developing an evaluation system for training programs has been the focus of a grant made to the University of North Carolina. This effort to assess and critically evaluate the procedures used in the University Affiliated Centers will be continued.

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HEARING, SPEECH, AND LANGUAGE

Obligations Fiscal Year 1972 to Fiscal Year 1976

Agency and Program	1972	1973	1974	1975 estimate	1976 estimate
National Institutes of Health:					
National Institute of Neurological Diseases and Stroke.....	$11,446,000	$10,240,000	$12,164,000	$10,433,000	$12,359,000
National Institute of Child Health and Human Development...	10,810,000	11,869,000	15,612,000	13,300,000	13,200,000
National Institute of Dental Research.....	1,461,102	1,774,053	2,385,227	1,526,883	1,803,709
National Institute of Environmental Health Sciences	---	212,000	460,000	430,000	400,000
Subtotal, National Institute of Health.....	$23,717,102	$24,095,053	$30,621,227	$25,689,883	$27,762,709

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NATIONAL INSTITUTES OF HEALTH

National Institute of Neurological Diseases and Stroke
National Institute of Child Health and Human Development
National Institute of Dental Research
National Institute of Environmental Health Sciences

HEARING, SPEECH, AND LANGUAGE

Goals of the National Institute of Neurological Diseases and Stroke (NINDS) program in communicative disorders are diagnosis, amelioration, treatment, and prevention of hearing, speech, and language disorders. This research program is implemented through grant projects, directed research contracts, and intramural laboratory research.

The NINDS program in communicative disorders includes 136 research projects, including two out-patient clinical research centers, 12 contracts, 52 training grants to universities and medical centers, and six multidisciplinary centers. In addition, the Institute last year created a new Laboratory of Neuro-Otolaryngology to study the biochemical, anatomic and physiologic processes of the auditory system and to develop better methods of preventing and treating auditory disorders.

NINDS also has a Communicative Disorders Section which is expanding its directed research into new problem areas, particularly those which do not receive funding from other Federal agencies. These include improved objective identification of young hearing-impaired children; better measurement, treatment and prevention of speech and language disorders among adults who have experienced stroke or head trauma; effects of noise on children; noise and speech communication; and improved assessment and treatment of language communicative disorders not apparently attributable to sensory impairments. The Section is supporting research on wearable master hearing aids and on the extent to which deaf persons are able to integrate electronic analysis of speech.

The National Institute of Child Health and Human Development (NICHD) promotes understanding of developmental processes in persons of all ages. Research deals with normal acquisition and development of language skills and with problems of communication related to mental retardation. In addition, the NICHD studies the role which human communication plays in the individual's physiological, social and intellectual development.

In addition to the Institute's 209 research and training grants, the NICHD supports 12 Mental Retardation Research Centers which conduct investigations in language acquisition, and in the development and training of the mentally retarded child. Among the handicaps shared by the mentally retarded, language deficiencies are probably the most common and prevalent.

The National Institute of Dental Research (NIDR) supports research on cleft palate (an incomplete closure of the roof of the mouth) and other oral-facial defects. NIDR has awarded 12 research grants, including several to research treatment teams, five training grants and two fellowships for study of this anomaly which occurs once in approximately every 600 births. The NIDR has a program in its Bethesda laboratories on genetic aspects of deafness, notably in animal models. Part of this research is supported by NINDS funds.

The noise research conducted and supported by the National Institute of Environmental Health Sciences (NIEHS) is a part of its effort to determine what factors in the environment, operating singly or in combination, adversely affect man's health. Among the objectives are an identification of various environmental chemicals, drugs, and other agents which contribute to hearing loss, and an

investigation of specific endocrine, immunologic, pharmacologic, teratogenic, cardiovascular, and other mechanisms which may be affected by chronic noise exposure.

HEARING

The Problem

Impairment of hearing is the most prevalent chronic disability in the United States. The first survey of deafness in the United States in 40 years was completed this past year, and shows that there are currently 203 deaf persons for every 100,000 in this country--more than twice the number counted in the last census. In all, there are about 13.4 million people in this country with hearing losses, 11 million of whom can hear with some assistance.

In addition, an earlier national survey has indicated that the incidence of ear disease, which could lead to hearing loss if untreated, is far more prevalent than was previously thought.

While the ultimate goals of hearing research are the prevention and cure of hearing disorders, many basic questions regarding the nature of the hearing mechanism need to be answered before these goals are met.

The answers should come, however, with an increasingly precise understanding of the anatomic, physiologic, and biochemical processes. Much of the NINDS research is directed toward understanding these basic functions, but support is also given to clinical studies on improved treatment for afflicted persons.

A primary target for prevention is hereditary deafness, which accounts for approximately 40 percent of deafness at birth. More than 40 types have been identified, most of them resulting from defects in five or six genes. Recently NINDS grantees at Johns Hopkins University described two of these disorder complexes--one involving recessive microtia or abnormally small ears with hearing loss, and the second characterized by recessive achalasia or tense gastrointestinal muscles, piebaldism or absence of pigment in skin and hair, and hearing loss. Better understanding of the genetic nature of various hereditary disorders undoubtedly will aid in counseling prospective parents.

An additional 10 percent of deafness present at birth results from prenatal rubella infection. Data collected from the NINDS collaborative perinatal study of more than 50,000 women and their offspring, which was in progress during the rubella pandemic of 1964, showed that about one-half of the infants whose mothers had rubella during the first three months of pregnancy are deaf. Of these, approximately one-half also have impaired function of vestibular structures (part of the inner ear concerned with balance). Fortunately, the recently developed rubella vaccine promises to reduce the future incidence of rubella-caused defects in babies.

Recent advances in virology also help explain how other viruses are implicated in congenital deafness, and further improvement in prevention can be expected.

Hearing and Normal Communication

Persons with hearing handicaps are known to have difficulty learning to speak, yet many of the underlying relationships between hearing and the acquisition of verbal communication are not known. In order to elucidate some of these unknowns, NICHD supports research projects concerning the child's ability to respond to acoustic stimuli both for pure tone and for language-related complex sound. At St. Joseph's Hospital in Lancaster, Pennsylvania, for example, an investigator has recently demonstrated that the heart rate and EEG (brain waves) of normal and abnormal newborns can be consistently but temporarily changed by simple (pure tone) and complex (speech-like) acoustic signals. When developed

into a clinically applicable technique this procedure should prove a reliable measure of an infant's ability to hear speech sounds.

Identification of Hearing Disorders

Hearing problems can best be managed when they are discovered early. The lack of a reliable test to screen newborns forced physicians to rely on a high risk registry to identify infants with a high probability of deafness, based on family history.

Several recent developments indicate that reliable tests may soon be available that will permit large scale screening for all newborns. An apparatus for detecting a continuous lack of response to auditory stimuli has been introduced by an NINDS grantee at Stanford University. The device, called a "crib-o-gram," when mounted on a crib can detect infant movement in the crib and record any changes when a test sound is turned on. Criteria for "passing" or "failing" the test have been developed through a control study of 5,000 babies. Infants are considered to hear if they respond more than 20 percent of the time. The equipment is capable of testing a large series of babies daily; results are tabulated by computer.

A second test being developed by NINDS-supported researchers at Baylor University utilizes objective procedures which may be applied to very young children. The test is based on findings that measure ear drum movement in response to different types of noise and can be used to predict hearing threshold levels. On the basis of these findings the scientists have evaluated the acoustic reflex threshold for pure tones and bands of noise in 1156 patients in an attempt to predict sensori-neural hearing loss.

The new test, which proved highly accurate, holds great promise as a predictive test of hearing loss in children. The procedure can be done with a child of virtually any age with a minimum of difficulty. A manual on how to use this and other procedures on very young children is now being prepared by the NINDS.

NINDS-supported researchers at the University of Chicago have developed a research technique for obtaining an objective test of hearing function which may be useful in small children and hearing impaired adults. Called electro-cochleography, it picks up electrical impulses which are produced in the cochlea (the organ of hearing in the inner ear) and monitors the excitations believed to be produced by different stimulating frequencies. Results are computerized and emerge as patterns.

Still another screening test for hearing disorders is being developed by NINDS-supported scientists at the Eaton-Peabody Eye and Ear Clinic in Boston. In an attempt to determine the functional state of the auditory nerve fibers, researchers are recording auditory nerve signals from the ear canal following acoustic stimulation with tones of successive frequencies. It is hoped that this painless, non-invasive technique can be used as an office procedure to diagnose otologic problems.

Several NINDS grantees have shown enthusiasm for brain stem audiometry in which computer-summarized brain waves are analyzed to determine functioning of the auditory system. Proponents of this approach believe they are able to detect in the averaged computer output the neural activity which occurs at each progressively higher level of the central auditory system. Evaluations of this approach are in progress and if shown to be successful could have extensive clinical use. Procedures such as this undoubtedly will help to more accurately assess persons unable to participate in voluntary hearing tests such as young children, the mentally retarded, and accident victims.

Behavioral Audiometry

Because of the need to better understand the effect of hearing impairment on speech and language development and the impact of speech and language problems on the mentally retarded, the NICHD has developed a major contract at its University of Washington Mental Retardation Research Center on the language acquisition of normal, hearing impaired, and Down's Syndrome children. This project is primarily concerned with children under three years of age. One of the major advances of the project is in the area of assessing the hearing (audiometry) of infants under one year of age. This involves the use of both impedance audiometry, which requires no active participation by the infant, and behavioral audiometry in which the infant is trained to respond every time he hears auditory test signals. Impedance audiometry provides information about specific parts of the auditory system, primarily the middle ear. Behavioral audiometry provides information about the auditory system as a whole, and about the functional relation between the infant and his auditory environment. To date the team has been able to obtain meaningful data from infants as young as five months of age. The assessment of auditory abilities during the first year of life has major significance for early intervention programs.

Other investigators have based their behavioral audiometry procedures for infants on the work of NICHD grantees at the University of Kansas Mental Retardation Research Center where operant audiometry was developed to test profoundly retarded individuals. The researchers at Kansas have extended their use of basic operant audiometry in threshold testing to teach even severely retarded children to make auditory discriminations. Once a child is systematically trained to respond, by being brought under stimulus-response control, a variety of tests can be administered. Such a training program can be a basic key to training in other forms of communication.

The development of the operant model for hearing assessment has been reported in a number of research journals and recently in a book titled A Stimulus-Response Approach to Audition. Benefits derived from this procedure permit the child to be considered for supportive amplification such as a hearing aid, and to be placed in educational programs compatible with the child's hearing status.

Advances in Treatment

While much of NINDS research involves basic studies necessary to understanding the nature of the hearing mechanism and its disorders, support is also given to clinical studies on treatment.

Thirty types of hereditary deafness are known in which the onset is delayed. The most common of these is otosclerosis, which is characterized by growth of spongy bone in the middle ear bone (the stapes) that normally vibrates and conducts sounds to the inner ear. Today this disorder can be successfully treated and hearing restored in most patients. Surgery has been an important advance for the management of this disorder. It consists of removing and replacing the stapes. The procedure has become increasingly safe with refinement of microsurgical techniques and is reported to be effective in more than 90 percent of the patients.

Another condition in which surgery can prevent not only hearing loss but death as well is acoustic neuroma. Safe removal of these tumors growing on the sheath covering the acoustic nerve is possible because of striking advances in methods of early diagnosis and microsurgery.

Surgery is also being used sparingly for some persons with Meniere's disease. This disorder, characterized by hearing loss, tinnitus (ringing in the ears), and vertigo, often will respond to medical measure including diet regulation, control of allergies, and drugs. In some persons for whom these measures are not adequate, cryosurgery and ultrasound are used in the inner ear, destroying

the end organ of balance (the vestibule), but preserving cochlear (hearing) function. However, even when surgery is performed, symptoms often recur with a slow progression of hearing loss. Improved management of Meniere's disease is expected to come with increased understanding of the inner ear (vestibular) mechanisms.

Still another contributing factor to hearing loss can be otitis media, an inflammation of the middle ear. Otitis media commonly develops from infection in the nose or nasopharynx. It can cause up to a 35 or 40 decibel hearing loss if left untreated, but is easily treated with antimicrobial agents and oral or topical decongestants. (A decibel is a unit of hearing.) Serous (or secretory) otitis media results from fluid collecting in the middle ear, often after prolonged blockage of the eustachian tube (the pressure equalizing connection between middle ear and nasopharynx). Serous otitis media, usually unaccompanied by pain, can also cause hearing losses often undetected for considerable periods of time. Although effective treatment can usually be achieved with oral and topical decongestants, enzymes, myringotomy (surgical puncturing of the eardrum), and antibiotics, serous otitis media frequently recurs. Since one hypothesized explanation for recurrence of serous otitis media is eustachian tube malformation, some current research is centering on the mechanisms of eustachian tube function and management of tubal disease. NINDS scientists plan to evaluate the comparative efficacy of several treatments for serous otitis media.

Presbycusis

Even when no external direct causes of hearing loss are evident, with increasing age there is a frequent variable sensori-neural and discrimination hearing loss. This hearing loss accompanying the aging process and known as presbycusis remains one of the most prevalent, and as yet incurable hearing problems. Scientists have identified pathological changes in the temporal (ear) bone, including degeneration of certain inner ear structures. Other studies have indicated that diseases of the blood vessels may be responsible for the degeneration seen in presbycusis.

The NINDS has recently established a new laboratory of applied psycho-acoustics which will focus attention on the hearing problems of persons with acquired sensori-neural hearing loss, such as those with presbycusis. The goals of this laboratory will be not only to understand the nature of these disorders, but to develop measures to prevent them or to ameliorate them when prevention is not possible. Studies by NINDS-supported researchers at The Johns Hopkins University indicate that various factors may be involved. The investigators demonstrated a loss in volume but not in number of auditory neurons.

Ototoxic Agents

Over the past few years a number of drugs have been found to cause loss of hearing. These include streptomycin, dihydrostreptomycin, neomycin, and ethacrinic acid. The toxic doses and site of injury have been defined for a number of these agents. To alert practicing physicians, and provide researchers with current information on drugs which are or may be toxic to hearing, the NINDS-supported Information Center for Hearing, Speech and Disorders of Human Communication last year published the "Index-Handbook of Ototoxic Agents, 1966-71."

Advances in Basic Research

Efforts by NINDS scientists to understand the physical aspects (anatomy and physiology) of audition have yielded real advance. However, the transducer mechanism by which mechanical or sound stimuli are converted to electrical signals and relayed to the brain remains to be elucidated.

Recently in animal studies investigators have attempted to record signals from the interior of the auditory sensory cells. These cells are believed to contain the critical mechanisms that convert mechanical energy to electrical energy and thereby trigger the hearing process. Scientists believe that these studies may serve as a model for understanding the human hearing functions.

An important first step has been taken by NINDS grantees at St. Louis in defining the chemical substances in the inner ear and the auditory portions of the brain that transfer information from one neuron (nerve cell) to another.

One way to study hearing disorders is to grow the organ of hearing in tissue culture. Two NINDS-supported research groups (at Wisconsin and New York) have removed from mice the fetal precursors of the hearing organ and have been able to grow the organ with its auditory nerve in culture. With this technique they can study the sensory cells in normal animals and in animals with genetic defects of the organ of hearing and/or the auditory nerve. These pioneering studies of mammalian hearing are vitally important. Not only is there a wide body of genetic knowledge on the mouse, but an animal model such as this may be used as a model for hearing disorders in humans.

Coordinated efforts by NINDS-supported scientists to study the auditory portions of the brain stem are expected to produce increasing information on how nerve cells are interrelated and how auditory information is transformed and encoded.

Prosthetic Devices

Many scientists believe that the key to a successful implanted hearing device will come from discovering how the normal ear encodes auditory information and how this information is utilized by the central nervous system.

At the request of the Secretary of the Department of Health, Education, and Welfare, the NINDS met with a representative group of researchers to discuss the current status of the feasibility of an implantable cochlear auditory prosthesis. As an outgrowth of that meeting, two workshops on the cochlear implants were held, one at Bethesda and one more recently in San Francisco. Although recognizing the formidable obstacles in developing such devices, the conferees agreed that answers to the many problems in this area should be vigorously pursued.

Research on auditory prosthetic devices for the deaf is in progress at a number of universities, medical centers and private companies. One type of sensory prosthesis under study by NINDS researchers involves the direct stimulation of the auditory nerve, the primary nerve of hearing. Preliminary trials with prosthetic devices indicate that pitch and amplitude can be discriminated but complex tones and speech cannot. Understanding of the coding process would greatly enhance chances for success with this type of prosthesis.

One investigator is studying the physiological responses in cats to stimulation by a multichannel electrode. The prevailing view is that encoding of intelligible speech, if ever possible, will require multichannel stimulation of a series of predetermined sections of the acoustic nerve. Scientists hope that if stimulation of a small number of predetermined sectors of the acoustic nerve can be accomplished, it may be sufficient for speech discrimination by subjects who are now profoundly deaf.

Hearing Aids

In addition to research aimed at developing prosthetic devices for the deaf, scientists are attempting to improve the quality of existing aids so that the hearing impaired can use their residual hearing more effectively. Research on hearing aids, which are wearable sound amplifiers, is designed to maximize

aids to the wearer's individual needs. The Institute supports work on this at Northwestern University and the Central Institute for the Deaf.

Last year the Institute developed, under contract, prototypes of two models of master hearing aids which will enable scientists to determine methods for tailoring hearing aids of maximum efficiency for the individual wearers. The NINDS is evaluating these wearable aids at the Graduate Center of the City University of New York.

A second type of sensory device that may help the deaf to perceive and understand speech is the sensory coding aid. These aids convert sound so that it may be sensed through vision or touch. In one NINDS-supported project, investigators are conducting preliminary studies in an attempt to augment the visual information from lip reading with visual or tactile information or "cues" by means of the use of electronic analysis of the acoustic speech wave produced by the talker.

Another system under development, as part of an NINDS-supported project at the Central Institute for the Deaf, extracts nasal vibrations, throat vibrations, and pressure near the speaker's lips and presents signals corresponding to these energy sources at three locations on the skin by vibrotactile means. Initial reports from this project indicate that significant, and sometimes dramatic improvements in intelligibility scores occur when the aid is combined with the lip reading technique.

In NINDS-supported studies at The Johns Hopkins University, scientists are developing and evaluating cutaneous (skin) and visual patterned stimulation aids to communication for the profoundly deaf infant. Tests are being conducted to determine the effectiveness of both visual-patterned stimulation and tactile-patterned stimulation on the development of vocalizations by these infants. During the past year it was found that even in this age group subjects can be trained to attend to both visual and tactile displays.

Noise

It is well established that exposure to noise of sufficient levels for sufficient periods can produce temporary, chronic, or permanent hearing losses. Exposure to noise can interfere with speech communication and with sleep; it can be a source of annoyance and can act as a stressing agent. Noise constitutes one of the leading threats to hearing. More than 16 million Americans may be exposed to dangerous noise levels on the job. Another 10 million urban dwellers are often exposed to harmfully loud noise levels generated in their home environment.

Recently the Environmental Protection Agency (EPA) issued noise-control regulations that eventually will ban from use any truck engines that are noisier than an automobile. The new rules, which also establishes noise limits for portable air compressors, will be fully in force by the 1990's. Compressors and trucks covered by the new rules--the first products affected under the 1972 Noise Control Act---are considered two leading sources of excessive noise, particularly in urban areas.

A recent development of importance in the area of noise is the concept of total daily noise exposure which is expressed as the L equivalent over 24 hours, or L_{eq}. The L_{eq} is variously described as the energy-equivalent level, the equivalent level or the average sound level. It summarizes for the first time sound energy from all daily noise exposure.

Because noise standards are based primarily upon data obtained from young, normal-hearing adults, some of the standards and criteria may not apply to children. This year the NINDS, in cooperation with the Committee on Hearing and

began to review available information and identify noise-related problems which may affect the health and welfare of children.

The conclusion from this review, soon to be published, suggests that levels of noise which interfere minimally with the performance of adults on tests of speech perception may interfere substantially with children's understanding of speech. This provocative conclusion will be investigated further under NINDS auspices. Furthermore, exposure to noise of sufficient levels for sufficient periods may affect the acquisition of speech and language, and listening skills.

Research supported by NINDS at a number of universities and research centers is providing an understanding of the basic physiological structures and functions that are adversely affected by exposure to noise. Some of these studies are providing a correlation between noise dosage accumulated over a person's lifetime and impaired hearing.

A group of NIEHS scientists studied the combined effects of noise and salicylates (such as aspirin) on cochlear morphology (structure) and the auditory threshold. Using electrophysical, biochemical, and radioactive tracer techniques, they also studied the changes in energy utilization and production under the influence of known ototoxic agents (e.g., noise, ethacrynic acid, etc.) and attempted to pinpoint the specific mechanism by which these actions occur in the cochlea.

Another study undertaken by this group concerned the investigation of auditory fatigue. These scientists investigated the sites and nature of the physiological changes underlying the temporary or permanent threshold shift, as well as the potential for auditory fatigue exhibited by subtoxic doses of antibiotics.

The NIEHS group also undertook a study to determine the nature of the interaction between noise and ototoxic drugs in experimental animals and to investigate the biochemical mechanisms involved in such losses.

Finally, to precisely evaluate how the ear handles acoustical information, these scientists continued work on the development of a middle ear transducer for delivering precisely quantified signals to the inner ear.

An NIEHS grantee is studying the effects of combined impulse and continuous noise on hearing sensitivity and cochlear anatomy. The extent of noise-induced trauma from these combined sources cannot be explained by addition of the acoustic power of the sources. These data are a necessary prerequisite for the ultimate establishment of damage risk criteria for impulse-continuous noise combinations.

SPEECH AND LANGUAGE

The crucial nature of the communicative sciences and the disorders which impair normal communication can best be assessed by considering the close link between thought, speech, and language. Language depends upon the activity of the cerebral cortex, the last division of the central nervous system to develop. The language areas of the brain are located in close proximity to the thought association areas. Furthermore, the mastery of language proceeds hand-in-hand with the development of higher forms of anticipatory behavior.

Normal Language Development

Language is a formal system of rules for using signs and symbols as a means of communicating. It is usually accomplished through spoken or written words. Currently approximately 3.5 million children between ages 4 and 17 years have some degree of language disability.

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The NICHD has supported several projects dealing with the acquisition of language. Because children everywhere learn spoken language as a matter of course, the complexity of the acquisition process and of language itself is frequently overlooked. The Institute, however, has encouraged scientists from many different disciplines to define the major unsolved problems and has stimulated research in how children develop language. A research contract has been developed with the Haskins Laboratories of New Haven which has provided over a hundred different scientists with natural and synthetic speech-like stimuli recorded in a precise manner suitable for a variety of experiments. As a direct result of this work, advances have already been made in speech and language perception which may lead to improved language and reading instruction, as well as better hearing aids for the hard-of-hearing.

The NINDS, through its program of directed research, is attempting to determine whether there is a crucial age during which normal or impaired children may develop language. Information drawn from a number of disciplines, including embryology, physiology, chemistry, and morphology, may lead to a better understanding of delayed language development in neurologically impaired children.

Language Disorders

Language development can be hindered or impaired from birth as a result of impaired hearing, mental retardation, infantile autism, or specific brain damage. Children who do not suffer from any of these problems but still fail to develop normal language skills often have what is termed a developmental language disability.

To reduce the impact of these disabilities on the development of social and cultural knowledge needed to function in society, recent efforts have focused on the early detection of children at a high risk of having a language disorder.

Directed research of the NINDS will be aimed at early detection and accurate differential diagnosis of children impaired in language and speech development. Techniques are being developed for testing infants' hearing abilities since the early development of auditory perceptual skills in infants provide the basis for early understanding of speech and later, learning to read.

Researchers supported jointly by NINDS and NICHD at the Parsons State Hospital and Training Center in Kansas, a special clinical and research center for mentally retarded children, are studying new strategies for training severely retarded children to learn skills which will enable them to learn language. The program includes training in auditory detection, speech sound discrimination, and categorization. The basis for symbolic communication is first taught through the use of small discs or forms upon which speech utterances are superimposed. This research should provide some insights into the basic skills which neurologically impaired children must develop in order to learn language.

Scientists are now assembling methods for examining the language development in all children of preschool age. The results will be used to assure parents that their child has learned each of the necessary skills in language before reaching school.

NINDS-supported scientists in Kansas have found that parents of children with certain learning disabilities can be trained to assist their child in developing better language skills. The children of such parents, who have been trained to assist them, develop these skills at a faster rate than other children. Hence if a learning-disabled child is detected at an early age and his parents are taught to assist him before entering school, the extent of the language disorder can be limited.

Perhaps the most dominant impression conveyed by a severely retarded person is inappropriate speech. Thus language is one of the most significant skills requisite to the placement of a retarded person in the social system. Indications are that the fruits of this research will have a significant impact on the traditional methods and procedures of language training.

A major NICHD program project at the University of Kansas Center has included work on information-processing and concepts underlying language usage (semantics). Results indicate that retarded persons use primarily passive techniques for learning material to be recalled later. However, retarded persons can be taught to rehearse materials and to use effective retrieval strategies. There is some indication that these learning and retrieval functions are not limited to components but may relate to the organization of learning and recall processes.

At another NICHD Center at Fernald State School, an automated method has been developed for increasing reading comprehension for severely retarded children. The method permits even Down's Syndrome children with I.Q.'s of 30 or less to learn simple reading comprehension. They are taught by using a simple machine to associate dictated words with pictures, and the same dictated words to their matching printed words. They then prove able to associate the printed words with their appropriate pictures. Having learned a basic reading vocabulary this way, they are then able to progress further by interacting with a teacher in a special education class. Without the automated method, most such children would not have been recognized as candidates for reading instruction.

Another NICHD project at the Center at Peabody College in Nashville is based on the assumption that positive intervention of nearly any sort at the earliest possible ages is likely to yield beneficial results for the developing child. Even efforts to train toddlers in language skills have demonstrated considerable success.

Adult Language Disorders

Language problems also occur in adults as a result of brain trauma, stroke, brain tumors, or infections. Usually the condition is diagnosed as aphasia, a severe language disorder that results in an inability either to assign meaning to words, to understand speech, and/or to organize words into thoughts. This devastating language disorder produces anxiety and confusion for persons who once had normal speech.

NINDS investigators at the Boston Veteran's Hospital have recently developed a substitute language system using visual symbols. Adult aphasic patients have been taught this new language system and use it to communicate effectively among themselves, hospital staff, and family members. Patients who have learned this substitute system are expected to regain some of their former language abilities more efficiently.

NINDS-supported researchers at Minneapolis Veteran's Hospital are developing a technique for describing the behavior of aphasic patients during therapy and identifying their difficulties in regaining language. This technique will provide new information for developing improved treatment techniques.

Normal Speech Development

There is strong evidence that a child's speech is acquired through a set of evolved, genetically based abilities. In fact, it would appear that the normal infant is born with a built-in capacity for speech. Unlike all other animals, most human infants acquire the speech patterns of their immediate environment more effectively than could be expected if "learning" were the only explanation.

studies on speech and language. He found that children acquire both the rules of language grammar and the rules for transforming the underlying meaning (deep structures) of the language to the spoken word (surface structure). Extending this concept, NICHD-supported investigators at Harvard are designing and testing methods of developing and assessing linguistic knowledge and communication skills in later childhood.

Another NICHD-supported researcher at Brown University revealed startling evidence that a five-day-old infant can discriminate between speech sounds (phonemes) such as "b" and "p." Speech and language scientists are now able to conclude that from an evolutionary view, speech perception, and other aspects of human language are genetically based and specific to the human species, but that there is much individual variation with the species.

At the Haskins Laboratories in New Haven, Connecticut, investigators supported by the NIDR are studying normal speech production by combining fiber optic viewing of throat motions with X-ray moving pictures, voice prints, and electromyographic recordings via electrodes placed in individual muscles. In an extension of previous studies of how patterns of muscle actions differ during rapid and normal speech, the patterns involved in stressed speech, such as occurs in excitement or other emotions, have been examined. The investigators thought the patterns would be similar as far as the signals to the muscles were concerned, and would differ only in the length of time for making vowels. They were surprised to find that the signals to articulating muscles were stronger and required more energetic muscle action, and also that the action pattern for the various muscles was quite different, uneven, and did not fit current theories of speech production.

Speech Disorders

Speech disorders resulting from disturbances in muscular control of the speech mechanism caused by damage to the central and peripheral nervous system are known as dysarthrias. Many are believed to arise from a disruption at the lowest level of nerve output. Disturbances within the nervous system can affect any or all aspects of speech production--respiration, phonation, articulation, and resonation.

In the past, several studies have been made on the perceptual and acoustic aspects of dysarthria which sometime accompany neurological disorders such as cerebral palsy, head trauma, multiple sclerosis, Parkinson's disease, tumors, dystonia, and many others. More recently this research has been expanded to include physiological and rehabilitative aspects of these disorders.

One NINDS grantee scientist at the University of Wisconsin is studying the coordination of muscular activity during speech production of dysarthric patients with neuromuscular impairments. The use of electromyography (to measure the electrical activity of the muscle fiber) to study lip movements during speech production has led to increased understanding of the bases for these patients' difficulties and the specific action of certain drugs on muscular function. As a consequence more effective therapeutic techniques have been found to increase the accuracy of patients' sound production.

Using lateral cineradiography (X-ray motion pictures), researchers been able to describe the nature of the disturbed tongue movements during swallowing and speech in patients with Parkinson's disease. Their results are defining the pattern and sequence of deterioration in vocal tract control in Parkinson's disease and can be applied to other progressive neurological diseases.

Characteristically, patients with Parkinson's disease have increased tension and rigidity of the muscles directly affecting speech. NINDS-supported scientists have utilized bioelectric feedback to reduce lip tension in a patient with Parkinson's disease, thus removing undesirable lip retraction.

NICHD grantees also are studying the acquisition and development of normal articulatory behavior to provide a basis for diagnosing and treating articulatory problems.

Articulation problems are the most common speech disorders, and seven out of every ten individuals with speech disorders have them. One NINDS-supported investigator in Seattle has developed a technique for measuring jaw displacement during the process of speech. This new technique together with the findings from the expanded research on the dysarthrias could provide assistance to the many children affected with articulation problems.

Nearly 70 percent of the mentally retarded have some articulation problems. Since most retarded children also manifest other language problems, the intelligibility of their communication depends even more on clear articulation. NICHD-supported investigators at Parsons State Hospital and Training Center and the University of Kansas have developed better methods for improving the articulation of retarded children. One of their major advances applies to the carry-over of more intelligible speech from therapy to everyday use. This is done by allowing stimuli which occur in the child's natural environment to reinforce correct responses acquired in the therapy session.

Laryngectomy and Cleft Palate

Speech disorders resulting from laryngectomy operations for cancer of the larynx are also being investigated. Dramatic advances have been made in maintaining or restoring speech function following surgery for removal of the larynx which contains the vocal cords. Improved methods of detection are enabling doctors to make an early diagnosis, before the damage is too widespread. In these cases, conservation surgery which removes only the cancerous parts of the larynx provides the best prognosis for the restoration of speech. Following recent approval by the Food and Drug Administration of the use of teflon (suspended in glycerin) for injections to strengthen remaining tissue, restoration of speech and the ability to swallow have been made possible in a large percentage of patients.

An exciting advance in larynx surgery was made recently by scientists in Massachusetts. They used a carbon dioxide laser integrated with an operating microscope to selectively evaporate predetermined amounts of abnormal vocal cord tissue. Removal is reported to be precise and rapid. Follow-up examinations indicate normal healing similar to that in clean surgical wounds.

A head and neck registry is being kept at Washington University in St. Louis to maintain statistics on the long-term survival rates and quality of life of patients who have undergone larynx removal. For those whose cancer is too widespread for conservation surgery, speech prostheses are being developed by several investigators, while others are conducting animal studies to evaluate the possibility of reconstructing a normal larynx.

NIDR-supported scientists at Haskins Laboratories report that the muscle patterns in nasal speech are very different from those in oral speech. In most speech sounds, the passage between the nose and throat (velopharyngeal gap) must be closed to force the airstream out through the articulators--lips and tongue. Most of this closure is controlled by one muscle in the palate. In contrast, m, n, and ng sounds require that some of the airstream be released through the nose. The investigator found that this release requires suppression of the activity of a number of muscles in the palate and side walls of the throat, and that these muscle patterns vary surprisingly from person to person.

An additional NIDR-supported study used fiber optics and muscle electrodes to visualize the production of sounds called stops (a guttural k) made deep in the throat voice box or larynx. In English only one type of stop is used, and that is made by alternately tightening and loosening the vocal folds which

vibrate across the voice box. However, other languages require a wider variety of stop sounds, and a comparison of those spoken by a visiting Korean showed that a number of other laryngeal muscles and their controlling nerves are involved in the production of two other types of stop.

Among speech studies designed to help the victims of cleft palate, one made at the University of North Carolina shows that, next to the ability to close the velopharyngeal gap, a very important factor to be considered for good speech is the subject's ability to control the size of the mouth opening while making fricative sounds (s, z, f, and v). If the opening is too large, the air pressure in the mouth portion of the voice tract drops too much to articulate these sounds properly. Often, cleft palate victims are so busy trying to close the back of the throat that it is hard for them to close the mouth. The tongue can compensate for other muscles for either the back or front opening but not for both at once.

On the other hand, a number of children with cleft palates habitually fail to open their mouths wide enough to speak properly. Speech investigators at Duke University found that simple bite blocks made from wooden tongue depressors and used for a few minutes a day in a summer camp for cleft palate teenagers is a great help in training them to develop better speech habits.

A speech specialist at the University of Pittsburgh compared several tests used in various speech and hearing clinics to indicate the vocabulary, language, and mental development of young children four to five years of age. She found that no single test reliably predicts performance of any individual child, and recommends that clinicians use more than one test in connection with the Stanford-Binet Intelligence Scale in order to get more reliable results.

Voice Prostheses

Experimental prosthetic aids include a pneumatic device called the LaBarge prosthesis developed by scientists in New York. The LaBarge prosthesis connects a fistula or hole in the neck to the esophagus so that the air used for breathing can also be used for esophageal speech by vibrating remaining tissue. This procedure, which has had limited use by human volunteers, is still in the investigative stage.

A new type of laryngeal voice prosthesis with no electronic components is undergoing development at the Northwestern University-McGraw Medical Center, Chicago, and affiliated hospitals. Unlike most other voice prostheses, the Northwestern model is designed particularly for those laryngectomy patients who have not yet learned or cannot learn esophageal speech. The artifical larynx can produce a very intelligible voice immediately.

Utilizing a hypopharyngeal pseudoglottis for voice, the device has an air bypass tube that shunts expired air from the trachea into a hypo-pharyngeal fistula. The fistula is placed high in the throat so as to take advantage of each patient's natural "vibrator" which has a slightly different location in each patient. Other earlier devices featured fistulas that were lower, near the esophagus--impracticable for patients who had undergone extensive esophageal surgery.

NINDS-supported scientists have provided clear insight into the dynamics of respiratory functions specifically associated with speech and voice production. Since there is a positive correlation between variation in pulmonary expiratory pressures and loudness of sound during phonation, direct control of the expiratory muscles is of importance for the production of speech.

A systematic clinical investigation by NINDS-supported scientists at the University of Florida of speaker identification and recognition utilizing eye, ear, and computer technology represents a major contribution in the communicative

sciences. Researchers have demonstrated that certain segments of the acoustical signal (voice print) are predictors of certain laryngeal pathologies. This non-invasive technique will permit early, accurate and painless diagnosis of certain laryngeal disorders. Animal and human hearing studies undertaken at the University of Florida compliment the speech investigation and are contributing to the development of a theory of speech production and reception.

NINDS-supported researchers at the University of Cincinnati and Washington University, St. Louis, are working to reconstruct the larynx from natural tissue. Animal studies at Cincinnati, for instance, have shown that a functioning larynx in dogs can be made from their own throat tissues. Studies are now being conducted to see if this procedure can be applied to baboons, whose upright stance is similar to that of man. Construction of the new larynx has been completed, and investigators are now attempting to refine construction of the vocal cords.

SHARING OUR RESEARCH FINDINGS

The dissemination of research findings and their application are considered by NIH to be one of its major functions. Each of the Institutes involved in communication research has held conferences and published proceedings. The latest of a series of conferences supported by NICHD on Communicating by Language was entitled, "The Role of Speech in Language." The proceedings will be published by the M.I.T. Press. A previous conference resulted in a book entitled Language by Ear and by Eye. Highlights of this book, which is now available in a paperback edition, are summarized in a NICHD pamphlet entitled, The Relationships Between Speech and Reading. Other publications in this NICHD series include The Speech Process, The Genesis of Language, and The Reading Process.

In co-sponsorship with its Mental Retardation Research Centers, the NICHD has also initiated a series of seminars which will result in state-of-the-art documents for the scientific community on aspects of mental retardation. Recognizing that language ability is a vital element in the development and performance of the mentally retarded, and that language deficiencies are the most commonly shared handicaps of mental retardation, the first seminar in this series deals with language and the mentally retarded. The proceedings resulted in a publication entitled, Language of the Mentally Retarded. To complement this effort a second conference was held bringing together basic scientists and clinicians in the field of language. This resulted in the publication of Language Perspectives--Acquisition, Retardation and Intervention. This conference and publication form a bridge between basic research and clinical application.

The NINDS-supported Information Center has had a number of workshops. The proceedings of many of these have been published, including Vascular Disorders and Hearing Defects; Sensory Input in Hearing Impaired Children, and Neuroanatomy of the Auditory System and Physiology of the Auditory System. The Center has also had issued several publications including: Index-handbook of Ototoxic Agents, 1966-1971; Biblio-Profiles (including Homotransplantation, Auditory Physiology, Otitis Media, Surgical Treatment of Deafness, Viral Infection and Hearing, Neuroanatomy of Speech, and Rehabilitation of Language Disorders in Children); research bibliographies; and two directories, Information Sources in Hearing, Speech and Communication Disorders--Publications and Organizations.

Available also from NINDS are the following publications: Human Communication and Its Disorders: An Overview--Monograph 10; Reading Forum--Monograph 11; Learning to Talk; and in the Hope through Research series, the following: Hearing Loss, Dizziness including Meniere's Disease, and Acoustic Neuroma.

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GALLAUDET COLLEGE

Gallaudet College: Gallaudet College, established in Washington, D.C. by an Act of Congress in 1857, has as its purpose to provide a liberal arts undergraduate education program for the deaf, a tutorial school for deaf students who need such training to qualify for college admission, a graduate school program in fields related to deafness, and a continuing education program for deaf adults. In 1975, an estimated 986 undergraduates and 212 graduate students will attend the College.

In order to promote student development, the College offers a wide variety of learning experiences and instructional options, mediated instruction, significant interaction with the larger society, and experiences which encourage growth toward self-fulfillment, including participation and practice in decision making. In addition, the College offers technical assistance to outside organizations and agencies and services to deaf individuals and persons concerned with the needs of the deaf.

Model Secondary School for the Deaf: Public Law 89-694 provides for the establishment of day and residential facilities for the secondary education of young persons who are deaf in order to prepare them for college, other advanced training or employment. The Public Law authorizes the Secretary, after consultation with the National Advisory Committee on Education of the Deaf, to enter into construction of such a school. The agreement was signed in May 1969. The completed school will serve residents of the District of Columbia and nearby states of Virginia, West Virginia, Maryland, Pennsylvania, and Delaware. In 1975, MSSD will have an enrollment of about 130 students.

The permanent facilities for the Model Secondary School for the Deaf (MSSD) are presently being constructed on the campus of Gallaudet College. The first phase of construction, including the academic building, will be completed in FY 76.

In one of the boldest experiments in the history of American education, students and staff have come together in a school with no classes, in classrooms with no walls, to seek new ways in which today's young deaf students may be educated toward more productive and meaningful lives. An open laboratory school which employs computer-assisted education, educational television, and individualized instruction, the MSSD is, hopefully, a promise of things to come for schools for the deaf throughout the country. It is expected that the MSSD will provide an exemplary secondary school program to stimulate the development of similarly excellent programs throughout the Nation.

Kendall Demonstration Elementary School: Under P.L. 91-587, Gallaudet College was authorized by Congress to operate Kendall Elementary School as a national demonstration school for the deaf. In 1975 approximately 175 children will attend the school from the Washington, D.C. area.

As a demonstration school, KDES is attempting to develop an exemplary educational program for children from the onset of deafness through the age of 15. The School also provides for a diagnostic center and a parent education program. Because of its special focus, Kendall School is also becoming a source of important research on the learning problems of young deaf children.

The obligations for fiscal years 1972-76 for Gallaudet College are as follows:

	1972 Actual	1973 Actual	1974 Actual	1975 Estimate	1976 Estimate
Salaries and expenses:					
Gallaudet College	$ 7,955,000	$ 8,779,000	$10,218,000	$12,269,000	$13,985,000
Model Secondary School	2,533,000	3,101,000	3,975,000	4,445,000	5,334,000
Kendall Demonstration School	1,214,000	1,905,000	1,995,000	2,328,000	2,691,000
Construction	2,832,000	14,495,000	9,473,000	19,181,000	3,522,000
Total	14,534,000	28,280,000	25,661,000	38,223,000	25,532,000

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NATIONAL TECHNICAL INSTITUTE FOR THE DEAF

Public Law 89-36 authorized the Secretary of the Department of Health, Education and Welfare to enter into an agreement with an institute of higher education for the establishment and operation of the National Technical Institute for the Deaf (NTID). The Rochester (N.Y.) Institute of Technology (RIT) was selected as the sponsoring institution. NTID is a residential facility offering postsecondary vocational education and technical training to deaf persons in order to prepare them for successful employment, a training center for preparing professional manpower to serve the nation's deaf population, and a research and demonstration center to help reduce the economic, educational, communication, personal and social negatives of deafness.

In FY74 NTID occupied its new facilities, imaginatively designed for deaf students so as to create a productive and effective learning environment. The current (FY75) enrollment of all students at NTID is a full-time equivalent of 700 with a planned increase to 960 in FY76. Current staff which includes instructional, supportive, clerical, administrative, research and training personnel totals 249.

The NTID program includes courses of study in Business Technologies, Engineering Technologies, Technical Science, Visual Communications Technologies, and Social Sciences that take into account deficiencies in the educational preparedness of incoming students, provide career counseling to help students select appropriate technical courses, provide special support services (such as interpreting and notetaking), and maintain liaison with industry and business for cooperative educational and in-service work experience. Communication skills evaluation and improvement are major components of the program. Computer technology and instructional television are being experimented with for use in enhancing the effectiveness of teaching deaf students who rely mainly on their vision for learning. NTID also has research and in-service training components.

The obligations for fiscal years 1972-76 are as follows:

	1972 Actual	1973 Actual	1974 Actual	1975 Estimate	1976 Estimate
Salaries and expenses	$ 4,636,000	$ 5,308,000	$ 5,826,000	$ 8,775,000	$ 10,980,000
Construction	26,190,000	1,915,000	1,400,000	1,981,000	---
Total	30,826,000	7,223,000	7,226,000	10,756,000	10,980,000

OFFICE OF HUMAN DEVELOPMENT

Office of Child Development

Hearing and Speech

The Office of Child Development, established in 1969, has advocacy and leadership responsibility for all children, including handicapped children. In line with this responsibility, OCD develops standards and guidelines for health programs and provides technical assistance to State, public and private agencies in an effort to help handicapped children. Within the Office of Child Development, the Bureau of Child Development Services administers Project Head Start, a comprehensive demonstration program for preschool children from low-income families. One of the key components of every Head Start program is the provision of health services, including health education, health screening and the treatment of identified illnesses and conditions. These services are also provided by Head Start demonstration programs, such as Home Start, Parent and Child Centers, and Child and Family Resource Programs.

The goal of the health component of Head Start and all its demonstration programs is to identify and coordinate existing health services to insure provision of health care to preschool children and their families. Head Start centers provide complete care to preschool children and their families. Head Start centers provide complete medical examinations, including visual acuity and hearing tests, and all programs focus on the early identification of health problems. During FY 1974, a pilot effort was launched in 200 Head Start programs to develop ways to insure maximum use of Medicaid Early and Periodic Screening, Diagnosis and Treatment Services for eligible children 0-6 years of age.

Head Start has always had a policy of encouraging enrollment of handicapped children, including those with speech and hearing defects. For FY 1976 Head Start will assure that 10 percent of the enrollment opportunities in each State are available to handicapped children. This is in accordance with the legislative mandate contained in P.L. 93-644, the Community Service Act of 1974. Prior to FY 1976 Head Start had implemented a policy of making 10 percent of the enrollment opportunities nationwide available to handicapped children.

As part of the new focus on the handicapped, Head Start programs are developing Speech, Language and Hearing Programs that make use of speech and hearing clinicians and of outside professional personnel in local clinics, centers and agencies. A special manual on the Speech, Language and Hearing program, recently developed for Head Start personnel, outlines a language and communications skills program for nonhandicapped children as well as those with defects requiring professional treatment.

In addition, 14 experimental projects demonstrate new approaches to serving handicapped children in Head Start. Eight of these projects are operated by Head Start programs and six are early childhood projects jointly funded by OCD and the Bureau of Education for the Handicapped (BEH) in the Office of Education. Two of the joint OCD/BEH projects focus on speech and hearing handicapping conditions.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

REPORT ON JUVENILE DELINQUENCY

A REPORT TO THE

HOUSE COMMITTEE ON APPROPRIATIONS

Obligations for Programs on Juvenile Delinquency

Agency	1973 Actual	1974 Actual	1975 Estimate	1976 Estimate
OFFICE OF EDUCATION:				
Elementary and Secondary Education				
Title I	$29,394,086	$26,647,623	$28,796,986	$28,796,986
Title III	660,000	660,000	594,000	330,000 1/
Vocational and Adult Education	2,000,000	2,000,000	3,500,000	3,500,000 1/
Library Resources	300,000	400,000	300,000 2/	300,000 2/
Higher Education	29,699	30,000	-0-	-0-
Teacher Corps	2,500,000	3,000,000	2,900,000	2,900,000
Subtotal, OE	34,883,785	32,737,623	36,090,986	35,826,986
ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION:				
National Institute of Mental Health	5,250,000	3,069,000 (3,617,000) 3/	2,102,000 (2,665,000) 3/	2,298,000
OFFICE OF HUMAN DEVELOPMENT:				
Rehabilitation Service Administration				
Basic State Grants	15,800,000	16,500,000	17,000,000	17,000,000
Expansion Grants	450,000	-0-	-0-	-0-
Rehabilitation research and demonstrations	700,000	50,000	100,000	50,000
Subtotal, RSA	(16,950,000)	(16,550,000)	(17,100,000)	(17,050,000)
Office of Youth Development Youth Services Systems	10,000,000	10,000,000	5,000,000	-0-
Subtotal, OHD	26,950,000	26,550,000	22,100,000	17,050,000
TOTAL OBLIGATIONS	$67,083,785	$62,356,623	$60,292,986	$55,174,986

1/ Programs previously funded under Title III of the Elementary and Secondary Education Act and under the Vocational Education Act are consolidated under proposed consolidated education grants programs.

2/ Programs formerly funded under Title IV-A of LSCA must be maintained at the minimum of 1971 level.

3/ Includes 1973 released funds.

JUVENILE DELINQUENCY

Introduction

The Federal Government is deeply involved in programs to prevent and control juvenile delinquency and youth crime, as well as programs to rehabilitate youthful offenders. The Department of Health, Education, and Welfare is directly involved in several programs concerned with community-based rehabilitation, institutional services, and research and training.

The term juvenile delinquency is applied to a wide range of behaviors that young people engage in and to society's response to these behaviors, including both criminal and noncriminal behaviors. Criminal behavior includes those offenses of serious crime such as homicide, aggravated assault, forcible rape, robbery, and those of simple assault, forgery, drunkedness, drug abuse, disorderly conduct, and so on. Noncriminal behavior ranges from status offenses to dependency cases. Status offenses are offenses that would not be unlawful if engaged in by an adult (truancy, running away, curfew violations).

The youthful offender not only loses status and potential as he is drawn into the juvenile justice system but he becomes an item in the mounting cost of juvenile related crime. It has also been noted that youthful offenders have the highest recidivism rates.

Dealing with these problems within the Department of Health, Education, and Welfare are programs in the Office of Education; the National Institute of Mental Health in the Alcohol, Drug Abuse and Mental Health Administration; and the Rehabilitation Service Administration in the Office of Human Development. In 1975, OHD's Office of Youth Development phased-out its support of youth service systems which were delinquency preyention oriented. This was in accordance with the mandate of PL 93-415, the Juvenile Justice and Delinquency Prevention Act.

OBLIGATIONS FOR PROGRAMS ON JUVENILE DELINQUENCY

AGENCY	1973 Actual	1974 Actual	1975 Estimate	1976 Estimate
OFFICE OF EDUCATION				
Elementary and Secondary Education				
Title I	$29,394,086	$26,647,623	$28,796,986	$28,796,986
Title II	660,000	660,000	594,000	330,000 1/
Vocational and Adult Education	2,000,000	2,000,000	3,500,000	3,500,000 1/
Library Resources	300,000	400,000	300,000 2/	300,000 2/
Higher Education	29,699	30,000	-0-	-0-
Teacher Corps	2,500,000	3,000,000	2,900,000	2,900,000
TOTAL	$34,883,785	$32,737,623	$36,090,986	$35,826,986

1/ Programs previously funded under Title III of the Elementary and Secondary Education Act and under the Vocational Education Act are consolidated under proposed consolidated education grants programs.

2/ Programs formerly funded under Title IV-A of LSCA must be maintained at the minimum of 1971 level.

OFFICE OF EDUCATION

REPORT ON JUVENILE DELINQUENCY

(Fiscal Year 1976)

Title I of the Elementary and Secondary Education Act of 1965, P.L. 89-10, was amended on November 3, 1966 by Public Law 89-750 to include education or educationally related services to children living in State and local administered institutions for Neglected or Delinquent children.

Grants are available to State agencies for those institutions which operate a school program and to local educational agencies for other public and private non-profit institutions for delinquents. Grants are based on applications which must describe the special educational needs of the youths in the institution and propose educational projects designed to meet the most crucial of those needs. While the Office of Education administers the provisions of the Act and provides program leadership, it is the State departments of education which are authorized by Title I to approve project applications.

In the 1974-75 school year, 24,796,986 will be allocated for 45,237 eligible delinquent children living in 536 State administered institutions. At the same time, approximately $4,000,000 will be allocated for 19,266 eligible delinquent children in 411 locally administered institutions. These children are to be served through grants made to local school districts.

Since the inception of P.L. 89-750, a major effort has been made to expand and improve educational programs for institutionalized children and return those children to their families and communities with modified concepts about education, themselves and society. The emphasis in programs has been toward improved, more relevant curriculum designed for the unique needs of the children, better teaching, and greater cooperation among institutions, schools and community. There is also an acute awareness of the fundamental need for relevant teacher and other related staff training as the major step for improving education in the institutions. Effective educational aid received by these children now is much less costly, to the taxpayer, in the long run. Growing relief payments and the need for ever-expanding law enforcement facilities are inevitable results if delinquent children continue unaided into adulthood as highly unproductive and disruptive products of the poverty cycle.

Actually, there are 116,805 institutionalized neglected and delinquent children in State and local institutions who are counted for computing allocations for 1975. With continued and increased funding, the opportunities are great for this program to develop the children while discovering more effective general approaches to compensatory education. The laboratory-like characteristics of education in institutions, the nation-wide scope of the relatively small and more easily managed program, and its involvement with agencies and activities concerned mainly with poverty, crime and education are factors pointing to a high level of future success.

Public Law 89-10, ESEA Title III, Supplementary Educational Centers and Services, enables schools to provide programs presently unavailable to children, to raise the quality of educational services already offered, and to stimulate the development and evaluation of experimental elementary and secondary education programs to serve as models. Fifteen percent of programs funds is mandated for projects serving handicapped children. Other funds are mandated for projects in guidance, counseling and testing.

Originally, the Commissioner made grants directly to local education agencies. Beginning in fiscal year 1971, 85 percent of Title III funds were administered by State educational agencies, with fifteen percent to be used at the Commissioner's discretion within the State.

Several of the Title III projects have components dealing with the problem of juvenile delinquency; and State departments of education generally fund some projects related to dropout prevention. However, specific information is not available as to the amounts obligated in this area. It is estimated that approximately $660,000 was obligated in fiscal years 1973 and 1974; and approximately $594,000 in fiscal year 1975.

In 1976, the Title III program will be included in a new consolidated education grant legislation program.

The Vocational Education Act of 1963, as amended, expended approximately $3,500,000 in fiscal year 1975 for children residing in juvenile institutions.

Increasing amounts of money and technical assistance are going into vocational education programs for delinquent youth residing in correctional institutions. Special projects for dropouts, many of whom might become delinquent without the self confidence that a salable job skill can give them, are operating in many States. Vocational education has the positive attribute of offering relevant education leading to a career objective, and hands-on activities without the emphasis on academics which may turn off students who are unable to meet certain of these standards. Therefore, it may be that vocational education has prevented possible delinquency on the part of many students from all income levels who want to be prepared for the world of work, be financially independent, and be able to receive the education they perceive as important to their future as adults.

These programs are generally planned and implemented in coordination with other agencies such as correctional, welfare, vocational rehabilitation, and employment service.

In Alabama, 36 programs were provided to train 2,381 students who were located in a Federal prison, in detention homes and in urban schools. Additional guidance services, remedial education, individualized instruction and additional equipment and supplies were provided to maximize the success of economically and academically deprived students in 80 regular full-time programs.

Altogether, 2,900 students in Montana received help in programs designed to assist them in selecting occupational areas of interest or to succeed in further training for employment. These individuals were reported as socio-economically disadvantaged, correctional inmates, juvenile delinquents, and dropouts. Teachers in five schools provided independent study classes for pregnant teenagers so they could remain in school and continue their education.

Mobile Vocational Education Units provided services to penal institutions in Leesburg, Clinton, Annandale, and Rahway in the State of New Jersey. During American Vocational Education Week, a special presentation was arranged with the New Jersey Public Broadcasting Authority which included programs at the Yardville Correctional Institution. Visits were made to Rahway, Leesburg, and Annandale Prisons to explore methods of implementing the "Introduction to Vocations" curriculum in the Prisons' educational programs.

The Youth Forestry Camp in Custer State Park in South Dakota is providing vocational training for the boys confined there. At the State Penitentiary, 115 inmates were enrolled in nine vocational programs.

In Maryland a new office occupation program was developed and funded to serve youth in the Department of Juvenile Services. A non-occupational program, vocational evaluation, was also developed by the Department of Juvenile Services and implemented at the Forestry Camp in Western Maryland.

Also in Maryland funds were provided for maintenance of the approved vocational programs at Victor Cullen School and to support the position of vocational coordinator for the Division of Juvenile Services.

In Mississippi, 53 programs were operated in two juvenile correction centers as well as in public secondary schools. The programs included occupational orientation, skill training, and remedial related services.

Under the Trade and Industrial Education Program in Ohio, guidelines for a two-year law enforcement program for the secondary level were developed and disseminated to all vocational directors in the State.

Also in Ohio, the Akron City Schools leased two facilities to provide new approaches to training and adjustments for 172 malcontented and disruptive girls and boys. These two facilities, several miles from the city, are open-environment settings to provide an informal and flexible adjustment and education programs. The programs are designed to meet the special social, academic, personal, as well as vocational and prevocational needs of the participating students.

The staff of the Wyoming State Department of Education has written and disseminated new materials and guidelines pertinent to occupational education to all schools (K-14) including the University of Wyoming and State youth correctional institutions.

Title I of the Higher Education Act of 1965 pioneered in bringing college and university resources to bear upon the community problem of juvenile delinquency. As more substantial amounts of money became available through other programs in Health, Education, and Welfare and the Department of Justice, activities supported by Title I diminished. However, a few projects of an experimental nature are still supported and they include the training and counselling of youth in correctional institutions; and helping disadvantaged out-of-school young people to rediscover their academic abilities and pursue further training. In fiscal year 1974, an estimated $30,000 was applied to juvenile delinquency projects with approximately 450 participants. No funds were requested for the Title I program in fiscal year 1975 and none are requested for fiscal year 1976.

Under the Library Services and Construction Act (LSCA), Title I, projects are funded which benefit many juvenile delinquents whether they live in State or local institutions or in their own homes. Under this State-administered Act, public library services are extended in areas where they are inadequate; and libraries are improved in residential facilities operated or substantially supported by the State.

Increasingly, public libraries are developing outreach projects which take appealing multi-media materials into inner city neighborhoods, migrant camps, detention homes, half-way houses and other places not usually reached by more conventional library services. Bookmobiles, storefront libraries and "instant" libraries are attracting former "non-users", including many young people. Libraries with outreach services cooperate effectively with other agencies in conducting crime prevention, drug education and post-release programs.

Since 1968, juvenile correctional facilities have been among the State institutions eligible for grants under LSCA. Usually an institution receives a grant for one or more years for the purpose of developing its library, extending services to all residents, and providing qualified staff. The institution or its parent

State department then assumes responsibility for financing and administering the library and the State library agency continues back-up services, i.e., consultative and training, and interlibrary loan of books, films and other materials.

A report from Arkansas in 1974 shows that four correctional units for young people were supported in part with funding from LSCA. These units were visited by State consultants and special staff an average of five times during the year. Purposes of visits were to provide technical assistance and special programs for the residents. Using filmstrips, records, cassettes, and picture story study prints from the State Book Center, programs such as book talks, "sing-alongs" discussions, and story hours were given. A list of the audio-materials purchased with LSCA funds (available from State Center) was sent to all the institutions with special encouragement to borrow them. Progress was seen throughout the State.

Of the three training schools, two for boys and one for girls, the boys' training schools have certified school librarians. The teacher/librarian of the girls' school has 12 hours of library science training and is not yet certified. None of the schools has adequate space, but the Boy's Training School, at Wrightsville, is building a school addition containing a large library. The libraries are included in their schools' budgets. Each of the boys' schools have regular programs of film strips, book talks, and story hours for younger boys.

The Rehabilitation Center at Hot Springs added a part time librarian with an MLS degree. This enables the library to give better service to its patrons. The library has a GED collection which is used extensively. Attendance and circulation have steadily increased. The library is included in the institution budget.

A report from Florida shows the Desoto Correctional Institution (DCI) in Arcadia moved into larger quarters with a 30% increase in floor space.

The added space is utilized by an audiovisual section and a newspaper/magazine reading area. About 70 percent of the equipment and materials were ordered under an LSCA grant. The audiovisual section, accommodates 15-20 men with individual carrels and small group participation tables. Equipment includes microfilm readers, tape players with instant replay features, stereo disc players, 8mm loop projectors and filmstrip and slide projectors. These materials support the equipment "systems" with a variety of offerings which span the interest curve from non-reader to college levels, including programmed courses in beginning and intermediate Spanish.

The DCI Library is open 7 days per week, with a 70-hour per week schedule with the assistance of Educational and Vocational staff members. Inmate library aides assist staff personnel to provide services during the evening and weekend hours in addition to regular assignments.

Teacher Corps corrections projects, as well as standard projects, operate over a 2 year period. Since 1968, 18 sites in corrections have been funded, averaging about 10% of the overall Teacher Corps effort.

In fiscal year 1974 the four 7th cycle sites completed their second year of program operation. Fiscal year 1974 also included three new starts being funded for a first year of operation as part of the 8th cycle. Fordham University and Sacramento State College were refunded to allow them to build upon initial project experience. The University Without Walls is the sponsor of the one of the new starts. In this effort, 4 colleges in 4 different states are providing programs leading to undergraduate degrees for prison inmates, guards, ex-offenders and institutional staff. As teachers, project graduates are expected to continue to teach in settings similar to their own current situations.

For fiscal year 1975 four sites were funded in Vermont, Arizona, New Jersey, and California. These assist the public schools in developing and testing improved educational programs for delinquents, youthful offenders, and students with serious behavior problems.

In fiscal year 1976 it is expected that three or four new sites will start focused in the juvenile area and with public school systems. The Vermont, Arizona, New Jersey and California efrts continue a second year during fiscal year 1976.

As with Teacher Corps generally, these new efforts will shift the teacher training focus from one of primarily training intern with some retraining of existing staff occurring, to an effort that is primarily retraining existing site educational personnel, with a small (4 interns) team of corps members as the nucleus.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

National Institute of Mental Health

Obligations for Programs on Juvenile Delinquency

1972 Actual	1973 Actual	1974 Actual	Appropriation 1975 Estimate	Rescission 1975 Estimate	1976 Estimate
$6,914,000	$5,250,000	$3,069,000 ($3,617,000)1/	$2,336,000 (2,958,000)1/	$2,102,000 (2,665,000)1/	$2,298,000

1/ Includes 1973 released funds.

Delinquent behavior is a major social and political problem in American society. Almost half of all persons arrested in the United States last year for serious crimes, (e.g., homicide, robbery, and burglary), were under 18 years of age, while three-quarters were under 25.

Understanding the causes and dimensions of delinquency and promoting remedies is a complex task. First, delinquent behavior stems from the interaction of biological, psychological, social, and economic factors. Whether or not a particular pattern of behavior is considered "deviant" or "delinquent" depends on societal norms, reactions, and an administrative judgment of persons who make decisions regarding the processing of such individuals.

Given this premise, it follows that "delinquency" involves societal definitions and labels applied to certain types of behavior believed to require official sanction and control. A particular act may be viewed as delinquent in one jurisdiction, but as tolerable yet annoying behavior in another; similarly, deviant acts which some consider delinquent may be viewed as "mental illness" by others. The same deviant behavior, therefore, may be defined quite differently depending upon who the deviant person happens to be, the persons who observe or complain about the behavior, the circumstances under which the judgment is made, and the availability of alternative societal problem-solving resources. Consequently, in view of the vague, unreliable, and inconsistent labels and definitions ascribed to deviant behavior, it is imperative that efforts to better understand and cope with such problems give special attention to the actual behavior.

At the same time it is important to learn more about the factors which lead to the application of different labels (e.g., "delinquency," or "mental illness") to similar behavioral acts, the application of the same labels to different behavior, and also the factors which determine that no labels at all will be applied. The labels themselves can be important since different consequences may result from their application.

In recognizing that the same behavior may well be perceived, evaluated, labeled, and handled differently as a function of varying social contexts, the National Institute of Mental Health is concerned with the prevention, control, and treatment of deviant behavior which may be defined either as mental illness or as violations of the criminal law. The Institute's role, therefore, in the area of delinquency (the role of which is inextricably related to its emphasis on understanding human behavior) is to develop and disseminate knowledge about this special area of societal concern. In focusing on behavior rather than labels, there is both potential and actual overlap of "client" populations of the criminal justice and mental health systems. Deviant and maladaptive behaviors must be studied within the same broad context of the behavioral, social, and biological sciences as normal and adaptive behavior. To confine studies of social deviance to offenders will limit and seriously constrain our understanding of these complex phenomena.

Needed Knowledge on Delinquency-Related Behavior

Basic to the development of improved means for the prevention, control, and treatment of delinquency-related behaviors is the need for more precise knowledge on the sources, frequency, nature and dimensions of these behaviors. Such information can add significantly to scientific understanding of psychological and social forces that affect mental health and behavioral performance of individuals and groups. In addition, such information can add greatly to the understanding of social forces that operate on individuals and which have a major role in developing policy decisions with respect to the handling of individual behaviors that are perceived as troublesome, offensive, threatening, or harmful to others.

Juvenile Behaviors

Several studies using longitudinal, age-cohort, and survey research techniques are expected to provide important information on the dimensions of delinquent behavior.

Results from a National Survey of Youth comparing delinquent behavior among 13 to 16 year olds from 1967 to 1972 show that the amount of delinquency has not changed but that the style has. Boys in that age cohort in 1972 reported less delinquent behavior than their peers in the 1967 survey; but they admitted to markedly different kinds of offenses. Specifically, more of the 1972 male respondents reported more frequent use of illicit drugs--mostly marijuana--than the 1967 respondents did, and less larceny, threatened assault, trespassing, forcible and non-forcible entry, and gang fighting. The girls in 1972 also reported greater use of drugs--mostly marijuana but including alcohol--than girls did in 1967, while reporting less larceny, property destruction, and breaking and entering. But the decline of the latter kinds of offenses among the girls in 1972 does not balance their greater use of drugs, hence the girls in 1972 reported more delinquent behavior overall.

A longitudinal study investigating the transition of non-metropolitan youth from adolescence to adulthood is underway. Youth who were sophomores in the high schools of a non-metropolitan Western county in 1964 have been followed to learn of the extent to which pressures toward juvenile and young adult deviance originate in problems of adolescent stress. The study is also examining the competing commitments to education, work, family, and community on the maturational reform process and the effect of wartime military service on maturation and deviance. Such data have important and theoretical implications concerning the occurrence and maturational process of delinquency. These studies will provide data that will make it possible to compare metropolitan to non-metropolitan delinquency and deviance for the first time. Findings to date suggest that rural youth have just about as many contacts with the law as urban youth and the delinquencies are often equally serious. One in four youth had an official record with the county juvenile department. Almost half of the youths who had gotten in trouble with the law had done so more than once. 11% of the rural youths accounted for one-third of the contacts with the law. While 25% of the study group were regarded as delinquents while in high school, 28% committed one or more offenses between the ages of 18 to 23. Surprisingly, 51% of the young adult offenders had no recorded trouble with the law while a juvenile, which calls into question the assumption that adult deviance is largely the outgrowth of juvenile misbehavior.

Another study of self-reported delinquent behavior of institutionalized and non-institutionalized youth found that the pattern of offenses engaged in by high school females tended to be the same, though less frequent, as those engaged in by high school males and institutionalized males. A large proportion of offenses reported by the youth were committed in isolation from other youth. Those youth who tended to commit offenses in isolation were much less likely to have been picked up by the police than those who tended to commit their offenses in association with others. Furthermore, almost all respondents indicated that a majority of delinquent acts were unplanned and spontaneous. Such information will have important implications for understanding various situational aspects of juvenile delinquency.

Violent Behaviors

Individual violent behaviors are of concern since they are the most harmful to society and most frequently involve serious acts.

An important area of scientific inquiry concerns the possibility that individuals with certain biological abnormalities may engage disproportionately in such behavior. The NIMH is supporting several studies to determine the extent (prevalence) of chromosomal abnormalities in different population groups. Contrary to earlier and widespread speculations in the scientific as well as popular press, persons with certain chromosomal abnormalities (47,XYY) are not necessarily prone to antisocial and violent behaviors. As a group, prisoners and inmates of security hospitals with the XYY karyotype appear to be no more dangerous or violent than non-XYY prisoners and hospital inmates in the same institutions.

Another study is examining possible interactive relationships between perinatal brain damage and later antisocial behavior; the investigators are examining the birth records of 9,000 children in Denmark, where a system of medical recordkeeping makes this type of study possible.

Information on Decision-making Related to Juvenile Delinquency

Research is being done to focus on factors and criteria influencing decisions by police, prosecutors, and judges with respect to the application or non-application of sanctions to particular types of deviant behaviors and with respect to the movement of persons into and out of the juvenile and criminal justice systems at various stages. Several projects are attempting to improve our understanding of official policies and practices which relate to the handling of juvenile behaviors.

A study in Arizona, for example, is examining the relationship over time between official and unofficial measures of juvenile delinquency. The study is looking at the tolerance of officials, such as police and probation officers, to various forms of deviance and delinquency, and the relative seriousness that officials, delinquents and the general public hold toward a variety of offenses. The central purpose is to discover how reactions to deviance are affected by levels of tolerance held by various sectors of the community. Information learned through studies such as this are important in providing a substantial understanding about the societal reactions to juvenile violations and about the factors that affect official delinquency rates. This study has been of considerable interest to the Arizona Criminal Code Commission, which is currently in the process of considering revisions to the code. They are particularly interested in the public's knowledge of certainty and severity of penalties for different kinds of criminal acts, the public's knowledge of existing criminal statutes regarding different kinds of crime, and especially what the public thinks ought to be done to different types of offenders.

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Another study is testing labeling theory as an explanation of delinquent career development and evaluating the impact of police diversion programs on juvenile offenders. A third investigation is looking at three alternative practices of the police (screening, diversions, and referral to the juvenile court) in handling youthful offenders. These studies will have important implications regarding theories and related practices in the crime and delinquency field.

Development of Community-Based Treatment Models for Juvenile Problems

There is increasing social concern about the prevention and reduction in confinement of troublesome juveniles in training schools and related total institutions. Despite professed remedial and therapeutic objectives, the actual results of such institutionalization are often destructive to the youth and even appear to exacerbate existing problems. A longitudinal research study conducted by NIMH indicated that short-term intensive intervention in the community at an adolescent crisis period can alter delinquent boys' academic learning, personality functions, and overt behaviors in ways that foster positive, productive adjustment to society.

To facilitate non-institutional treatment programs the NIMH has been concerned with the development and testing of new community-based treatment models suitable for implementation by local communities. The interest is to develop, test, evaluate and refine an experimental program that appears to hold promise of effectiveness and replicability as a community-based answer to problems of delinquency or crime. The various models being developed represent treatment packages which can readily be exported elsewhere with minor modification to adapt to local problems, conditions, or settings.

The Achievement Place project has involved the development and testing of an intensive community treatment program for adolescent boys as an effective and economical alternative to institutionalization. Achievement Place is a community-based, family-style residential halfway house for six to eight boys between 11 and 16 years of age. The therapeutic approach and rehabilitative techniques utilized in the home by the "teaching parents" have been derived from basic learning principles developed by experimental psychologists and utilized in a wide variety of fields. These learning principles are used to influence the social and interpersonal behavior of the youngsters, their school behavior, their relations with parents and peers, and their development of self-control skills. This program has established ties with the juvenile court, the department of welfare, schools, and parents. The model group-home treatment also features the close and active involvement of an advisory board drawn from members of the local community in the planning and operation of the program. To meet the wide demand for application of this outstanding model, a training component has also been developed to train "teaching-parents." Likewise, a "how-to-do-it" manual and other user-oriented materials have been produced to facilitate ready utilizaion of this treatment model. Forty-four homes based on this model are operating in 14 states. These homes work with delinquent boys and girls, the mentally retarded, and adolescents with drug and alcohol problems. Support for these homes comes from State agencies, local groups, the Law Enforcement Assistance Administration and the National Institute on Drug Abuse.

An investigator in Oregon has been developing a community-level model which attempts to help parents with their delinquent children. This study is predicated on the notion that appropriate changes in parenting behavior can successfully alter delinquent or pre-delinquent behavior. The parent training procedures are derived from a social learning framework which carries the assumption that behavior is controlled by its contingencies, i.e., the consequences contingent upon the behavior. Very simply stated, parents are taught that their children's behavior is a close reflection of the reinforcing contingencies supplied within the family. Instruction is provided in the development of skills in careful observation, specifying behavioral goals and objectives, the steps to be taken by the child in achieving these behavioral objectives, and identifying contingencies to maintain those behaviors. Current research would extend this model to train mental health professionals, and also to extend the treatment model to the treatment of adolescent delinquents and their parents.

Another project is concerned with programs which public junior high schools can use in meeting needs of disruptive and under-achieving students. Originally developed and tested in a suburban school, the programs have since been applied in a more rural setting and in an inner city school characterized by a high proportion of students from broken and economically deprived homes. The model is based on the assumption that children and youth need to acquire a basic set of interpersonal and academic skills in order to function competently in society, and that most frequently it is a deficiency in these skills that gets youngsters into trouble.

Mental Health and the Legal System

The fields of law and mental health are both concerned with problem behavior of individuals. The courts frequently request mental examinations for the purpose of assisting determinations on issues such as pre-trial competency, exculpatory insanity, sexual psychopathy, civil commitment, and presentence evaluation, etc. In addition, the courts and the criminal justice system generally have been moving to the position that many types of problem behaviors traditionally handled within the province of the corrections system can be dealt with far more effectively outside that system--and at far less cost to society--provided suitable alternatives are available. Such diversion efforts have emphasized the greater role of the mental health system and agencies.

Several projects supported by NIMH are concerned with the need for empirical criteria on which to make decisions about a wide variety of difficult law and mental health issues. It also is important that psychiatrists, psychologists, and other mental health professionals consulted by the courts use more precise and empirically based criteria in order to avoid the confusions between therapeutic and the strictly legal concepts in the making of judicial decisions.

One project is addressing the virtual absence of clear-cut criteria for determining dangerousness of the criminally insane, the role such estimations play in involuntary mental hospital commitments, and the relationship of dangerousness to demands for social control. The study encompasses the effects of labeling dangerous different types of criminally insane patients, operational definitions and techniques for measuring dangerousness, changes in the administration of due process of the criminally insane, organizational and procedural adaptations of the civil state hospitals, and an ongoing evaluation of the effectiveness of the new treatment.

A third project is developing empirically based criteria for assessing the "adequacy of treatment" provided to persons who are involuntarily committed to mental institutions. Such criteria would be of much assistance to courts and to mental health personnel.

Training

The NIMH has been concerned with training mental health service professionals and behavioral and social science researchers in the delinquency field. Given the continuing gap between service needs and the availability of mental health manpower, efforts have been made to provide support for experimental training models for service professionals and nonprofessionals. The emphasis has been on developing more innovative, effective, and efficient models aimed at improving the functioning of service delivery agencies, for example, the use of nonprofessionals (including ex-offenders). Continuing education for mental health and criminal justice policy makers has also been an area of concern. Moreover, as policies and procedures for handling and treating juveniles change, the NIMH has been concerned with developing more appropriate and effective models for training manpower to meet these emerging needs.

Finally, and consistent with the experimental nature of these projects, the NIMH is interested in learning more about the effectiveness of such training models. For this reason, experimental training models are required to include an evaulation component to assess effectiveness of the training and its general impact in reference to the needs and objectives underlying these efforts.

Training Community-Based Treatment Practitioners

Growing out of research with the group home treatment programs (Achievement Place in Lawrence, Kansas), is a training project to develop a practical model for educating husband and wife teams known as "teaching-parents." The trainees learn how to set up such a program in a new community setting; to manage a token economy to help motivate the youths in a pleasant, nonconfronting manner while maintaining a friendly, home-like atmosphere. The teaching-parents also learn to counsel and work with the youths' natural parents, and to establish and maintain good public relations with the school, neighbors, and social welfare agencies, the juvenile court, police, and the community.

Another program is providing behavioral training in Vermont for foster parents and potential foster parents of unmanageable or delinquent children. There have been few if any programs that have made attempts to train foster parents to care for problem youth, and the number of parents who will currently accept an adolescent foster child who has been in trouble is very low. The program hopes to determine if the training process enables the foster parents to be more effective and whether this will increase the number of prospective foster parents who would be willing to take a troubled youth into their family. The training is based on behavioral principles and procedures and will provide the sort of structure and immediate relevancy that parents need in dealing with problem youth.

Legal problems of juveniles are too often ignored by the practicing bar. In an effort to address this manpower need, another project is providing law students with clinical training in the representation of juveniles in hearings on delinquency, neglect, dependency, and supervision petitions. The primary goal is to increase the number of new lawyers who have experience representing children, who feel committed to such work and who will contribute, over time, to improving the quality of the legal system as it relates to juveniles.

Training Evaluation Researchers for Community-Based Programs

Numerous social action and service programs have been supported by State and local agencies to meet problems associated with delinquency. In addition, various groups in the community such as youth and minority group members, have developed informal programs designed to treat their members whose behaviors are defined as deviant by the larger society. While both formal and informal organizations and groups may provide services and generate innovative methods of treatment, rarely do these programs provide for adequate and systematic evaluation to assess their efforts. One reason for this lack of assessment has been the absence of qualified manpower. Typically, agency evaluation efforts are more concerned with basic statistics and budgetary accounting than with more systematic and substantive evaluation of program effectiveness. In order to address this need, the NIMH is supporting two projects to train students in a specially designed 2-year Master's degree program, with particular concentration on evaluative skills relevant to social action programs related to problems of crime, delinquency, and social deviance.

Monograph Series

The Center for Studies of Crime and Delinquency has been especially concerned about the need for and the importance of disseminating high quality and up-to-date information to various policy makers, program administrators, and interested lay persons. Thus, various monographs and related publications have been produced and widely disseminated.

One series of short monographs is intended to inform administrators, decision makers, community leaders, and other interested persons about research results in significant crime and delinquency topics that are also of mental health interest. These monographs point to gaps in knowledge and suggest directions for future program development. This mongraph series has included: The Juvenile Court: A Status Report; Diversion from the Criminal Justice System; Community Based Correctional Programs: Models and Practices; Graduated Release; Civil Commitment of Special Categories of Offenders.

Another series of longer mongraphs has been produced under contract of a number of outstanding authorities and has been devoted to the thoughtful and in-depth discussion of important issues in the crime and delinquency area. Several of these monographs have been adopted for use in educational courses given by colleges, universities, and police academies. Numerous unsolicited letters have been received from academics and professionals in the field, commending this monograph series and its high quality. Requests for copies are received from many foreign countries as well. This monograph series includes the following titles: Perspectives on Deterrence; Legal Sanctioning and Social Control; The Functions of the Police in Modern Society; Instead of Court: Diversion in Juvenile Justice; Development and Legal Regulation of Coercive Behavior Modification Techniques; Correctional Treatment in Community Settings; Not the Law's Business: An Examination of Homosexulaity, Abortion, Prostitution, Narcotics, and Gambling in the United States; Competency to Stand Trial and Mental Illness; and Routinizing Evaluation: Getting Feedback on Effectiveness of Crime and Delinquency Programs.

In addition, there is a series of Research Reports in an effort to make available information gained from research programs to other researchers, program administrators, and others who are involved in the crime and delinquency and mental health fields. Examples of Reports include: Achievement Place: A Model for Delinquency Treatment; Helping Schools Help Children; The St. Louis Experiment: Treating Antisocial Children in the Open Community; Teenage Delinquency in Small Town America; and Predictive Sentencing: How Best to Rehabilitate Teenage Traffic Offenders.

Collaboration with Other Agencies

To facilitate and to maintain close contacts and liaison with other Federal and private agencies, NIMH staff meet with representatives to discuss programs and policies in the crime and delinquency field. Of particular importance is the continuing and on-going consultation and collaboration NIMH staff have had with representatives of the Law Enforcement Assistance Administration, especially in reference to the implementation of the Juvenile Justice and Delinquency Prevention Act of 1974 (P.L. 93-415). Other activites include consultation with such agencies and programs as: the Office of Youth Development (DHEW), the Manpower Administration of the U.S. Department of Labor, the U.S. Office of Education, the National Institute of Education, the National Science Foundation, and the Police Foundation.

Conclusion

In summary, the NIMH has been engaged in an experiment to develop and identify appropriate program objectives, integrate research and training into a unified strategy to achieve these objectives, and also to facilitate information dissemination and research utilization. Such efforts have been designed to make the program more accountable in addressing critical social policy and problem areas in the delinquency field with models and strategies necessary for social action.

OFFICE OF HUMAN DEVELOPMENT

	1972	1973	1974	1975 Estimate	1976 Estimate
Rehabilitation Services Administration					
Basic State Grants	$15,600,000	$15,800,000	$16,500,000	$17,000,000	$17,000,000
Innovation Grants	175,000	-	-	-	-
Expansion Grants	450,000	450,000	-	-	-
Rehabilitation training	2,000	-	-	-	-
Rehabilitation research and demonstrations	813,000	700,000	50,000	100,000	50,000
Subtotal, RSA	$17,040,000	$16,950,000	$16,550,000	$17,100,000	$17,050,000
Office of Youth Development					
Youth Service Systems Program	$10,000,000	$10,000,000	$10,000,000	$ 5,000,000	$ -0-
Total, OHD	$27,040,000	$26,950,000	$26,550,000	$22,100,000	$17,050,000

OFFICE OF HUMAN DEVELOPMENT

Rehabilitation Services Administration

State rehabilitation agencies have been active in the development of programs and projects designed to provide vocational rehabilitation services to the juvenile delinquent. These services to the youthful offender have been provided generally under the Basic Support program in cooperation with State and Federal correctional agencies and probation offices as well as with State training schools and municipal courts. Programs vary in scope from the assignment of part-time counselors to correctional institutions, to the installation in reformatories of comprehensive vocational rehabilitation units.

For example, the Wisconsin rehabilitation agency has served delinquents in a forestry camp and school setting. Arrangements have been made for high school courses at local schools, while a work adjustment center focuses on vocational skills. In another example, the North Carolina rehabilitation agency has developed, in cooperation with the Department of Corrections, a special program for the mentally retarded youthful offender. This project involves prevocational, personal adjustment, group and individual counseling, and recreational services.

Under its Training grant authority the Rehabilitation Services Administration has supported conferences which bring together professionals from both the correctional and rehabilitation fields to explore ways of working more closely together. In addition, social workers and rehabilitation counselors being trained in programs supported by RSA Training grants often have an opportunity to take field training in agencies working in the field of juvenile delinquency. Although the primary emphasis is on the development of professional competence for work with the handicapped, the field experience in correctional institutions and other juvenile delinquency settings is a significant aspect of approximately eight vocational rehabilitation training projects.

Office of Youth Development

In 1975, 40 project grants for local Youth Service Systems were awarded to phase-out the Youth Service System Program authorized by the Juvenile Delinquency Prevention Act, which expires June 30, 1975. Technical assistance, training, and information services necessary for the phasing-out of the entire program were also provided

Prior to 1976, the Office of Youth Development assisted States and localities to coordinate their various programs and resources available for the prevention, treatment, and control of juvenile delinquency. This was accomplished through the award of grants or contracts to public or nonprofit agencies to implement coordinated youth service programs. Along with funding coordinated youth service systems, training and technical assistance is furnished through grants or contracts to assist in the development and operation of youth service programs and in matters relating to the prevention of delinquency. Since 1971, the Youth Development Program supported 103 youth service systems (YSSs) throughout the Nation. These provided integrated services to allow agencies to work together to achieve common objectives.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

House Appropriations Subcommittee Supplementary Data

(Fiscal Year 1976 Congressional Hearings)

MENTAL RETARDATION PROGRAMS

Prepared by: The Office for
Handicapped Individuals

March 1975

COORDINATION OF MENTAL RETARDATION PROGRAMS

The thrust of the Federal commitment in combating mental retardation depends upon a highly coordinated interagency effort. Coordination is vitally important in administering the many varied and diverse programs serving the retarded. It is a fact that mental retardation cannot be confined to any single health, education, rehabilitation or welfare program, or any one disciplinary group. A coordinated program, therefore, must provide a broad spectrum of activities designed to attack the problem of mental retardation wherever it touches the lives of people.

During Fiscal Year 1975, an estimated $1.9 billion will be 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 to include the top level executives of the Department with the Under Secretary serving as Chairman. In addition, Regional Office staff were also assigned to coordinate mental retardation Regional activities. The mission of the Secretary's Committee on Mental Retardation remained the same; i.e., the responsibility for coordination of the Department's programs and activities affecting the mentally retarded.

On January 25, 1972, the Secretary of Health, Education, and Welfare directed the establishment of the Office of Mental Retardation Coordination. This new unit replaced the Secretary's Committee on Mental Retardation, and assumed responsibility for the functions of that office. The Office of Mental Retardation Coordination provided coordination and evaluation of the Department's mental retardation activities and served as a focal point for consideration of Department-wide policies, programs, procedures, activities and related matters relevant to mental retardation. The office also served in an advisory capacity to the Secretary in regard to issues related to the administration of the Department's mental retardation programs, and acted as liaison for the Department with the President's Committee on Mental Retardation.

On February 20, 1974, Secretary Caspar W. Weinberger announced the establishment of the Office for the Handicapped in the Office of Human Development. Legislative authority for the new office is defined in Public Law 93-112, "Rehabilitation Act of 1973," Title IV, Section 405. By authority of the Rehabilitation Amendments of 1974, the title was changed to Office for Handicapped Individuals.

In succeeding the Office of Mental Retardation Coordination, the Office for Handicapped Individuals organized to carry out its role to serve the handicapped while continuing to give necessary focus to the mentally retarded. All vulnerable populations became the concern of the new office. Priorities of the Office for Handicapped Individuals are:

To prepare a long-range projection for the provision of comprehensive services to the handicapped;

To continually analyze the operation of programs for the handicapped, and evaluate their effectiveness;

To encourage coordination and cooperative planning among programs serving the handicapped;

To develop ways to promote the utilization of research related to the handicapped; and

To provide for a central clearinghouse for information and resources available to handicapped people.

The Office for Handicapped Individuals organized an Interagency Committee which consists of representatives of all programs for the handicapped. Its functions are to provide a means of communication, information exchange and program development for agency staff concerned with Federal programs for handicapped individuals.

As the Office for Handicapped Individuals assumes its responsibilities to embrace the cause of all handicapped people, the President's Committee on Mental Retardation will provide leadership and expertise in behalf of mentally retarded individuals. The Office for Handicapped Individuals will continue to work with the President's Committee on Mental Retardation in matters involving the field of mental retardation.

The Office for Handicapped Individuals maintains a distribution list of over 13,000 names of persons and organizations which receive publications distributed by this Office and agency publications in the area of mental retardation and other disabilities. OHI has also represented the Department at national meetings of the American Association on Mental Deficiency, the National Association for Retarded Citizens, the Council on Exceptional Children, United Cerebral Palsy Association, and the Association for Children with Learning Disabilities. Publications and information were provided by Office staff to delegates during these meetings.

SUMMARY OF MENTAL RETARDATION ACTIVITIES

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

Most States have enacted laws related to phenylketonuria (PKU) and make screening for this disorder mandatory. Throughout the country approximately 90 percent of the total registered live births are being screened.

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 and crippled children's 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, extend screening programs, provide treatment services for physically handicapped retarded youngsters, increase inservice training opportunities, and

provide 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 Administration, in conjunction with the Division of Developmental Disabilities, Rehabilitation Services Administration, Office of Human Development, supports projects for the retarded which have service components of well-integrated comprehensive health and mental health programs.

The Division of Developmental Disabilities 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.

The Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 (P. L. 88-164) was amended October 30, 1970, by the Developmental Disabilities Services and Facilities Construction Act of 1970 (P. L. 91-517). The new Act was designed to provide the States with broad responsibility for planning and implementing a comprehensive program of services and to offer local communities a strong voice in determining needs, establishment priorities, and developing a system for delivering services. The scope of the present program broadened to include not only the mentally retarded but also persons suffering from other serious developmental disabilities originating in childhood, including cerebral palsy, epilepsy and other neurologically handicapping conditions. On December 28, 1971, the Division of Developmental Disabilities issued proposed regulations for the administration of this Act.

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. The amendments of 1969 (P. L. 91-230), signed into law April 13, 1970, consolidated all legislation relating to education of handicapped children in Title VI. The Bureau of Education for the Handicapped in the Office of Education administers Title VI, which is now referred to as "The Education of the Handicapped Act."

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 physical education and recreation for the mentally retarded and other handicapped children.

Research

The National Institute of Child Health and Human Development in the National Institutes of Health will support mental retardation research and research training grants to an estimated amount of over $17 million in Fiscal Year 1975. The National Institute of Neurological Diseases and Stroke, the National Institute of Arthritis and Metabolic Diseases, among other Institutes of the National Insti-

tutes of Health, also contribute to mental retardation research. These contributions directly or indirectly extend the efforts of the Mental Retardation Branch of the National Institute of Child Health and Human Development.

The Division of Research in the Bureau of Education for the Handicapped of the Office of Education now supports six Research and Development Centers to focus on the more difficult problems of evaluation, communication, instructional procedures, etc. of handicapped children. 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. New systems of dissemination are being built upon the foundations already developed by the Instructional Media Centers and a system of Regional Resource Centers currently are 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.

The Rehabilitation Research Branch Program of the Division of Research and Demonstrations of the Office of Human Development supports 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 to community participation. Current programs of research and demonstration are increasingly concerned with new approaches to retardation in ghetto areas. Emphasis is placed on the coordination and focusing of all relevant community agencies on the problems of the retarded. The Research and Training Centers Division continues to sponsor three Mental Retardation Research and Training Centers. They are continuing to seek out the cause of mental retardation, to assess the potential for education and rehabilitation, to develop training and remedial programs, to ascertain their actual learning and socialization difficulties, and to develop methods to more adequately motivate the retarded for work.

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. Some examples of support include studies of the epidemiology of mental retardation in a rural county, sensory integrative processes and learning disorders, children with congenital rubella, perinatal casualty reports, galactosemia screening, and sensory motor activity in the neurologically handicapped child.

Construction

The university-affiliated facility construction program is administered by the Division of Developmental Disabilities, Rehabilitation Services Administration, Office of Human Development.

This construction program is authorized under P. L. 91-517, the Developmental Disabilities Services and Construction Act of 1970, which supplants in part and expands the old mental retardation law of 1963 to allow for grants to States for planning, construction, administration, and services for the mentally retarded, cerebral palsied, epileptic, and other neurologically disabled individuals. University-affiliated grants are made also to cover the costs of administration and operation of facilities and for the training of physicians and other professional personnel vitally needed to work with the mentally retarded.

Continuing progress is being made in developing projects for the construction

of community facilities for the mentally retarded in widely scattered areas throughout the country. Facilities constructed under this legislation are designed to provide diagnosis, treatment, education, training or care for the mentally retarded, including sheltered workshops.

Income Maintenance

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. Effective in January 1974, the Social Security Administration added a new program, Supplemental Security Income (SSI), to provide payments to qualified aged, disabled, and blind persons, including the mentally retarded. Under Title XVI, an estimated 310,000 retarded individuals who are not entitled to Title II benefits were receiving payments under the SSI program by the end of Fiscal Year 1975.

Office of Education

Report on Mental Retardation
(FY 1976)

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 of Education for the Handicapped (BEH) is responsible for supervising and implementing current and new legislative authorities to provide funds for projects and programs relating to the education and training of and research on 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 overarching goal for Federal efforts in the area of education for the handicapped is to equalize educational opportunities for handicapped children. Only a bit more than 50 percent of the nation's more than seven million school-aged handicapped children receive needed special education services.

The main issues surrounding the Federal role in education for the handicapped are:

1. How can the limited available Federal resources be used in a catalytic and stimulative manner to bring quality educational services to the greatest proportion possible of the unserved 50 percent of the target group?

2. What is the best use of Federal resources in preventing identifiable handicaps from becoming serious disabilities in school and adult life?

3. What educational techniques and methods can be developed, introduced and adopted to insure handicapped children job skills to enter adulthood with a high probability of participation in society in a meaningful manner?

Six objectives have been adopted for the Federal programs for education of the handicapped:

I. National Commitment

To insure that every handicapped child is receiving an appropriately designed education by 1980 (75% by 1977).

II. Increased Services

To assist the States in providing the appropriate educational services to 75% of the handicapped by 1977.

III. Career Education

To assure that by the year 1977, every handicapped child who leaves school has had career educational training that is relevant to the job market, meaningful to his career aspirations, and capable of bringing him up to his fullest potential.

IV. Manpower Development

To assure that all handicapped children served in the schools (75% by 1977) have a trained teacher competent in the skills required to aid the child in reaching his full potential.

V. Early Childhood Education

To secure the enrollment of 750,000 (75%) preschool aged handicapped children in Federal, State, and local educational and day care programs.

VI. Severely Handicapped

To encourage additional educational programming for severely handicapped children to enable them to become as independent as possible, including reducing their requirements for institutional care, and providing opportunities for self-development.

In order to efficiently implement the program and carry out the Federal mandate, the Bureau is administratively organized into four major divisions under the Office of the Deputy Commissioner. Each of the major Divisions -- Personnel Preparation, Assistance to States, Media Services and Innovation and Development -- functions as an integral element in the total Bureau program for handicapped children. The following pages describe the functioning of each division as it relates specifically to mentally retarded children.

Services

Division of Assistance to States

Under this Division, there are two branches. One administers the Aid to States programs and the second operates the severely handicapped programs, which includes the Deaf-Blind program.

Aid to States Branch Programs

A. Branch Purpose.

The Aid to States Branch is responsible for administering and monitoring programs of assistance and also providing technical and developmental assistance to States in the design, development, implementation and review of State plans for the education of the handicapped. The Branch also serves as a clearinghouse of information concerning novel and/or effective approaches to special education in other States.

B. Historical Development

The purpose of Title VI, Part B, Education of the Handicapped Amendments of 1974, P.L. 93-380, is to provide funds for the States for the initiation, expansion and improvement of special education and related services for handicapped children at the preschool, elementary and secondary school levels; and may be used for the early identification and assessment of handicapping conditions in children under three years of age. Beginning in FY 1975, the state plan must include a goal of providing full educational opportunities to all handicapped children and provide for a procedure to assure the accomplishment of this goal, with priority for expenditure of funds going to serve children who are not receiving an education. The state plan must also provide for procedural safeguards concerning the identification, evaluation and educational placement of the children.

Part B funds are viewed as being used to produce a catalytic effect in the States, as opposed to providing continuous basic support services. Projects under Part B include such items as diagnostic services, curriculum development, instructional material, equipment, leadership activities, in-service staff training, etc.

C. Impact on Mentally Retarded

During fiscal year 1973, about $37.5 million was obligated for the Part B program. Of this amount about $12 million was expended in the area of mental retardation, providing direct services to 64,000 mentally retarded children. In 1974 the Part B appropriation increased to $47.5 million; $15 million of which provided direct services to 80,000 mentally retarded children. During 1975 and 1976, we are estimating that we shall be serving the same numbers of mentally retarded children.

The purpose of the P.L. 89-313 Amendment to Title I of the Elementary and Secondary Education Act is to provide assistance to the States for the education of handicapped children in State-operated and State-supported schools. A new provision, beginning in fiscal year 1975, requires that if a child is transferred from a State-operated or supported school to one operated or supported by a local school system that the P.L. 89-313 funds follow him there.

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 and day classes have raised their levels of expectations for such children. While this program originally had a relatively limited funding, significant results have been realized, especially in terms of planning for comprehensive services.

During fiscal year 1973, of $75.9 million expended, about $46.9 million was in the area of mental retardation, serving about 98,760 children. During fiscal year 1974 about $85.8 million was appropriated for this program. Of this amount, about $52.5 million went to mental retardation, serving about 103,600 mentally retarded children. In fiscal year 1975 we estimate that we will be serving 112,400 mentally retarded children.

Special Services Branch - Programs for the Severely Handicapped

A. Purpose

The Special Services Branch of the Division of Assistance to States monitors two special programs directing attention to severely handicapped children and youth. "Telecommunications for Severely Handicapped Children and Youth Who are Homebound," was designed to explore the effectiveness

of modern telecommunications technology in the provision of educational/training services to those severely handicapped children and youth who are homebound due to restricted mobility or other aspects of social performance of physical involvement. Programs for Severely Handicapped Children and Youth provides for the funding of projects which would provide in conjunction with relevant public and private agencies and organizations within a State, (a) a plan for comprehensive services designed to meet identified, developmental needs of severely handicapped children and youth; (b) a model, demonstration program providing direct educational and/or training services for these children and youth which can ultimately be replicated State-wide and throughout the nation; and (c) a dissemination strategy whereby information about exemplary program activities or elements will be made widely known to both professional and nonprofessional personnel working with or interested in the education/training of severely handicapped children and youth.

B. Assessment Needs

It is estimated that nearly one million severely handicapped children and youth are totally excluded from the educational system of our nation. At least 300,000 others are not receiving adequate services.

The principal problems delimiting the delivery of effective educational/training services to severely handicapped children and youth, in those areas where such services are mandated or supported, include: (1) extensive deficiencies in personnel with expertise and experience; (2) lack of adequate, functional facilities; (3) general void of appropriate curricula, methodologies, and education/training programs; (4) scarcity of specialized materials and equipment; (5) limited child and youth identification; diagnostic, prescriptive and placement services; and (6) a general apathy or lack of concern for the needs of such persons, as well as the near nonexistence of advocate groups organized and functioning on their behalf.

The extreme shortage of adequate facilities, staff, and programs, has in many instances limited placement options for severely handicapped children and youth to already overpopulated institutions where, with a lack of funds, facilities, and staff, it has been impossible to provide little more than custodial care. Under more fortunate circumstances there may be more appropriate programs as institutions, and a variety of education/training service capabilities in home communities through mental health clinics, group home, halfway houses, and interim care placement centers. The States of Washington and New York are among those implementing some of these techniques. The "Rosenberg Report", a study in New York State in 1969, found that almost one-third of the retarded children and adults institutionalized by the State could be placed in the community if there were appropriate mental health and day-school facilities for them. At the present time, adequate facilities for such placements are very limited.

Among the most isolated of all severely handicapped children are those who reside in the nation's "training schools for the retarded and mental hospitals for the emotionally disturbed." Many of these institutions are located far away from any developed community; often those in larger cities are in relatively isolated or inconvenient locations. Children in these institutions rarely leave the grounds of the facility and are almost never given the opportunity to participate in the educational programs of the local school district.

Despite programs administered under legislation such as P.L. 89-313, amendment to Title I, ESEA, which helps to serve nearly 175,000 children in State-operated and State-supported educational programs, tens of thousands of children are left on their own to pass their days without constructive educational programs or social therapy. Such critical personnel shortages exist, that often when services are provided, these services constitute little more than routine custodial care.

The failure to educate or train is still commonplace despite mandatory education laws and United States District Court statements. Pennsylvania Association for Retarded Children et al v. Commonwealth of Pennsylvania et al. states that every retarded child is capable of receiving some form of education and that the Commonwealth must provide a free public education in accordance with every child's abilities.

C. Current Activities

In fiscal year 1974, ten programs and five telecommunication programs were funded for the severely handicapped. The ten programs, totaling $2,246,659, will be set up as model demonstration programs to be replicated throughout the States. The five telecommunication efforts, totaling $1,557,477, deal with Telecommunications for Severely Handicapped Children and Youth who are Homebound. Telecommunications can be a link between severely handicapped children and the improvement of their social skills and enrichment of their general life situation. The following is a brief synopsis of "Telecommunications and Programs for Severely Handicapped Children and Youth."

D. Historical Overview and Future Goals

The Bureau of Education for the Handicapped has been particularly interested in launching a concerted effort on behalf of the severely handicapped because of the demand and apparent need for services to this population, the difficult financial position of local and state governments, and the extent of successful activities conducted in the programs for deaf-blind children, funded by the Bureau over the past several years.

Through the BEH objective and activities addressed to the needs of severely handicapped, we will undertake cooperative planning with related Federal agencies and with State departments of special education to target resources at this population. There will be a program of technical assistance to State education agencies to improve both their management and planning techniques so as to make maximum use of all Federal resources that can be dedicated to the needs of the severely handicapped.

The specific strategy proposed for implementation by BEH during fiscal year 1975 as an initial thrust toward meeting the educational/training needs of severely handicapped children and youth is: to develop and refine a national compact between BEH and selected States on the education and training for the severely handicapped. A tentative plan for such an agreement has been drafted to incorporate the major service delivery problems that will have to be considered, resolved and funded from State and Federal sources. The current intent is to discuss this plan in whole and in the broad spectrum encompassed by its several parts, with selected States. The objective of this year's activity is to engage in a dialog with these States to determine the feasibility and possible deficiencies of the task required to launch the implementation stage of such a national plan. In furtherance of the intent of this year's activity, it is visualized that we would pursue this effort along two lines: (a)

a technical assistance colloquy with the several States to explore various areas of mutual concern, and (b) the development of bench-mark data to be used tentatively in a preliminary assessment of the scope, quality and breadth of the plan.

E. Impact on the Mentally Retarded

The following statistical analysis denotes the current participants in "Programs and Telecommunications for Severely Handicapped Children and Youth." As it reflects in the data presented, 46% of the children served were considered to be severely mentally retarded and 28% were considered to be Multi-Handicapped. In terms of money expended, the percent reflects approximately: $1,749,903 to be expended on behalf of severely mentally retarded and $1,065,158 on behalf of the multi-handicapped.

PROJECTS BY STATE	Severe Mental Retardation	Severe Emotional Disturbance	Multi-Handicapped	TOTAL
Alabama	11	38	22	71
California	11	22	17	50
Indiana		30		30
Kansas	18	6		24
Michigan	14			14
New Mexico			57	57
Oregon		14	11	25
Rhode Is.			35	35
Washington	200	73		273
Wisconsin	102	20		122
Tele/C Indiana	33	7	10	50
Kentucky	18			18
N Y City		30		30
N Y State			100	100
Utah	21	3	10	34
TOTAL	428	243	262	933
%	46%	26%	28%	100%

Centers and Services for Deaf-Blind Children

A. Program Purpose

The purpose of this program is to "provide through a limited number of model centers for deaf-blind children, a program designed to develop and bring to bear upon such children, beginning as early as feasible in life, those specialized, intensive professional and allied services, methods, and aids that are found to be most effective to enable them to achieve their full potential for communication with and adjustment to, the world around them, for useful and meaningful participation in society and for self-fulfillment."

These centers will develop and provide services to children who are deaf-blind and have been deprived of their major avenues of learning and contact with the every-day experiences of life.

B. Historical Background, Legislation and Funding

Public Law 90-247 was signed on January 2, 1968. This legislation was in response to the rubella epidemic (German Measles) that swept the nation and left many children with auditory and visual impairments, as well as other handicapping conditions including mental retardation. Approximately 5064 children were left deaf and blind. There were no programs in existence for such children at that time. In 1969, the first eight regional deaf-blind centers were started. In 1975, we now have a total of 10 Regional Deaf-Blind Centers serving deaf-blind children in all 50 States and U.S. Territories.

Total funding approved for Centers and Services for Deaf-Blind Children is as follows:

1969	$1,000,000.00
1970	2,000,000.00
1971	4,500,000.00
1972	7,500,000.00
1973	10,000,000.00
1974	14,055,000.00
1975	12,000,000.00
1976	16,000,000.00

3832 deaf-blind children are in various types of educational programs located in public and private institutions and state hospitals for the mentally retarded. Some of the types of services offered by the Deaf-Blind Program are as follows:

1. Full and part-time education services (both residential and day.)
2. Diagnosis and Evaluation
3. Parent Counseling

4. In-Service Training

5. Short-term program (summer school, respite care)

6. Pre-vocational programs

C. Impact on Mental Retardation

Children born with rubella have many handicapping conditions; many of the children are mentally retarded or show evidence of mental retardation. 778 of our deaf-blind population are receiving services in state hospitals for the retarded. Many more of these children who are deaf-blind and mentally retarded are in programs at public and private institutions. Between 50-85% of children in deaf-blind programs have also been diagnosed as having some degree of mental retardation.

Division of Media Services

Under the Division of Media Services there are three major activities: Media Services and Captioned Films, Recruitment and Information, and Regional Resource Centers.

Recruitment and Information

The recruitment and information program comes directly under the purview of the Deputy Commissioner.

A. Program Purpose

(1) to link parents of handicapped children and youth with needed and appropriate educational and related support services through information and referral to state and local resources; by reaching through mass media, parents of handicapped children who have failed to find appropriate services for their children, to respond to public inquiries generated by media and by assisting local groups in their efforts to meet information and referral needs of parents; (2) to assist State and local planners in providing adequate and appropriate services to handicapped children by supplying valuable consumer feedback to the service delivery system; and (3) to encourage regular education teachers to pursue careers to become teachers of the handicapped.

B. Historical Development

The National Special Education Information Center is now almost six years old. In the past it has directed its greatest efforts to making direct responses to parents by answering telephone inquiries and responding to mail inquiries. It has advertised its services on radio and television and in newspapers. It has also sponsored talk shows by special educators on radio and television.

Currently it is continuing these major efforts, but expanding on them through surveys of existing services, support of local parent groups and provision of feedback to the State and local delivery systems.

C. Impact on Mental Retardation

The Center provides comprehensive information on needs, rights and services for handicapped children. It has answered a quarter of a million letters and more phone calls from concerned parents and provided infor-

mation to hundreds of parent organizations, and to Federal, State, and local agencies, which have passed along the information to individual parents. While its efforts have not targeted on any individual handicapping condition, the Center has had a great impact on the provision of services to the mentally retarded.

Media Services and Captioned Films

A. Program Purpose

This program, authorized under Part F of the EHA provides the handicapped learner with specific educational materials directed at his (her) educational needs. This purpose is being advanced through the operation of a National Center for Educational Media and Materials for the Handicapped and a network for Area Learning Resource Centers which focus on the development and dissemination of materials and media for the education of the handicapped. Another major purpose is the captioning and distributing of motion picture films and other media to the deaf and hearing impaired population.

B. Historical Development

During 1973 and 1974, more than 3,680 groups of hearing impaired persons, representing an audience of 2.85 million people, were reached through the Media Services and Captioned Film program. Of these, 1,320 were schools or classes for the deaf. The total audience for theatrical films numbered over 1.5 million with a monthly average of 3,200 showings.

The program circulated more than 600 different captioned educational films through its 60 film depositories.

In 1975 the number of groups of hearing impaired persons reached will exceed 3,900 (1,400 schools and classes for the deaf). The captioned theatrical and cultural films will reach a total audience of 1.3 million persons with a monthly average of 4,220 showings.

700 captioned educational film titles will reach an audience of 1.6 million hearing impaired children, with classroom showings averaging over 10,500 per month.

Support of the National Theatre for the Deaf is continuing, and a daily captioned evening news broadcast over the national PBS network was continued. Experiments to develop an electronic coding system to provide captioned television programming to a potential audience of more than 13 million hearing impaired Americans are continuing.

The National Center on Educational Media and Materials for the Handicapped is conducting a needs assessment of specific requirements and standards for media and materials for handicapped children. The network of 13 Area Learning Resource Centers and 4 special category centers is providing a national delivery system of educational media to handicapped children.

C. Impact on Mentally Retarded

The National Center on Educational Media and Materials for the Handicapped and one of the specialty centers associated with the National Center are actively working with the States in the development of media and materials for the mentally retarded and other handicapped learners.

Regional Resource Centers (RRC's)

A. Program Purpose

The Regional Resource Centers (RRC's) were established under Part C of EHA. Presently, there are thirteen (13) RRCs serving their respective regions in a role specifying assistance to States in developing an intrastate capacity in regard to the following educational services and to provide said services to the states' service-clients within service rules which are clearly reinforcing of local and state capacity: appraisal of handicapped children, diagnosis of learning disorders and prescription of educational programs of handicapped children. The RRCs are concentrating their efforts on development of resources and services for the unserved, underserved and difficult to serve segments of the handicapped population, i.e., poor inner city and rural populations including a high percentage of the ethnic minorities.

B. Historical Development

In fiscal year 1973, in conjunction with State and local education agencies, the program provided specific diagnostic, evaluative, prescriptive, remedial or supportive services. Program strategies were designed to achieve the catalytic effect of influencing practices to enable more children to be placed in regular school programs.

In 1974, the major concern of the centers was to improve the effectiveness of on-going practices and of developing and implementing the use of new techniques where none existed. The major objective was to assure that all geographical areas covered by RRC programs had access to services directly or through cooperative efforts. Coordination of planning activities with the National Media and Materials Center is to bring about a dynamic, interrelated resource system

In 1974, approximately 40,000 handicapped children received comprehensive services from six Regional Resource Centers. Approximately 200 State education agencies and 6,000 local education agency personnel received training through workshops, special study institutes, and technical assistance activities. Also, 2,000 severely and multiple handicapped children received services in addition to the 40,000 children mentioned above.

In 1975, considerable emphasis is being placed by the 13 RRCs serving their 57 client states on developing the SEA's "Master Plan" for special education services to handicapped children as the plan relates to appraisal and programming.

C. Impact on the Mentally Retarded

By the end of 1974, the RRCs had provided services to approximately 80,000 children, of which 30,000 were mentally retarded. By the end of 1975, the RRCs should have provided services to 104,000 children, of which 39,000 are mentally retarded. In addition, support will be provided to 400 State educational service agencies and 10,000 local education agencies who provide services to the Nation's handicapped children. The RRC program had budgets of about $7.2 million for each of these fiscal years.

ESEA Title II Projects for the Mentally Retarded

Title II of the Elementary and Secondary Education Act, administered by the Office of Libraries and Learning Resources in the Bureau of School Systems, provides school library resources, textbooks, and other printed and published instructional materials for the use of children and teachers in public, private, and special State elementary and secondary schools. Children with all types of handicapping conditions and their teachers are eligible participants. A review of a sample of projects under ESEA Title II indicated that materials provided for their use with ESEA Title II funds have been mostly audiovisual materials, and picture and easy books. A larger number of projects for mentally retarded children were supported with instructional materials under ESEA Title II during fiscal year 1973 than in the past. Examples of such projects in two States are:

Pohukaina School, Oahu, Hawaii - A dynamic school librarian, with creative and innovative ability, has built this school library into a place of joy and rejuvenation for the children in this school--severely mentally and physically handicapped. Many of her little patrons are wheel chair dwellers, unable to manipulate on their own initiative, but able to get to the library because she has provided ramps and aisle space to accommodate them. Through her initiative an organization of airline stewardesses has "adopted" the children in this school, and provided muched needed audiovisual equipment that many of the youngsters can use independently. Individual carrels (some made of large packing crates by the librarian) are set up with equipment plugges in and on the shelf above, the types of material for use in that piece of equipment. Audivisual materials have been provided through ESEA Title II funds.

Martin Luther School, Beatrice, Nebraska - A very practical program is being carried out for the trainable and educable mentally retarded pupils enrolled in this private school. Development of perceptual skills is combined with attainment of defensive reading skills, emphasizing functional words of everyday life, reading of signs, directions, numbers, pictures, and other matter leading to social independence. Teachers use flash cards, posters, picture books, newspapers, filmstrips, recordings, worksheets, pamphlets, and games to heighten pupil interest. Constant reinforcement and practice are built into the program to increase motivation and retention of what is learned. ESEA Title II funds supplied many of the materials used.

Title III of the Elementary and Secondary Education Act

As part of the comprehensive effort to demonstrate innovative approaches to solve the needs of handicapped children, Title III of the Elementary and Secondary Education Act as amended in 1966, mandated that 15 percent of its project funds be set aside for special education programs for the handicapped.

Title III projects, administered by the Bureau of School Systems, are not designed "to meet the needs of handicapped children" but rather to demonstrate the solutions to critical problems in American education as they relate to the handicapped. It is recognized that the needs of these children will be met when appropriate programs are designed and implemented but this should not be the major thrust of Title III funds for the handicapped.

In many respects the intent of the legislation has been met. In other respects it has not. As more sophisticated procedures for identifying handicapped children are developed, as projects to serve these children are conceived, as the innovativeness and creativity of the project designs are improved, Title III personnel, working jointly with special education personnel and other local, State and Federal agencies will be in a better position to meet the mandate of the legislation.

In fiscal year 1976 Federal support for Title III will be included in a new consolidated education grant legislative program.

Vocational Education Act, Part B (Bureau of Occupational and Adult Education)

Under the Vocational Education Amendments of 1968 which were funded in fiscal year 1970, a number of programs were developed by vocational education agencies in fiscal year 1970, a number of programs were developed by vocational education agencies in which 115,300 handicapped persons were enrolled. Vocational Education reports do not give data by category of handicapping conditions but a review of reports indicates that the majority of enrollment increased to 203,781 with the same emphasis being given to the Educable Mentally Retarded. In fiscal year 1972, enrollment rose to 221,342 and it is evident that a wider segment of the handicapped are being served. Deaf, Blind, Crippled, Emotionally Disturbed, and Mentally Retarded Educable and Trainable were all listed among the categories being served. Unvalidated information indicates that the largest single category is still the Mentally Retarded with more than half of the enrollments being so diagnosed.

1973 Total handicapped enrollees in vocational education 228,086

Enrolled at secondary level	161,635
Enrolled at postsecondary level	30,736
Enrolled at adult level	35,715

A project entitled An Assessment of Vocational Education Programs for the Handicapped Under Part B of the Vocational Education Amendments of 1968 was performed by Olympus Research Corporation and the final report was submitted to the Office of Education, Planning, Budgeting, and Evaluation. This report indicates that in a representative sample of vocational education programs for the handicapped in 19 States, 84% of students diagnosed as handicapped were categorized as mentally handicapped: 66% were eudcable mentally retarded; 12% were trainable mentally retarded; 4% were learning disabled; 1% were emotionally disturbed, and 1% were educationally handicapped; 15% were physically handicapped and 1% were multi-handicapped.

Mentally retarded are being served in special classes in State schools, in local educational agencies, and in regular vocational education programs in vocational schools. In most programs the objective is to provide those services and program modifications which will assist the mentally retarded person to become employable at the highest level of which he/she is capable. We are finding that we have underestimated the potential of many and are modifying our approaches to provide more individually prescribed instruction and better assessment of potential through use of Vocational Rehabilitation/Vocational Assessment programs and through other assessment tools.

Inservice training of vocational education instructors to enable them to better serve the handicapped has been supported at the National level and is being offered in all States under State Department of Education, Vocational Education Division. Teacher Training Institutions for Vocational Education Leadership are becoming increasingly active in providing preservice and postgraduate education for vocational education instructors concerned with handicapped students.

In most local programs, any mentally retarded adults that are served are included in the regular groups. As the Adult Education Program is expanded to serve more adequately groups with special needs, mentally retarded adults will be provided specialized programs, with increased cooperation between the Adult Education Program and local programs and services designed to serve the mentally retarded.

Training

Division of Personnel Preparation

A. Purpose

The Division of Personnel Preparation of the Bureau of Education for the Handicapped initiates, maintains, and improves programs for the preparation of professional leadership and teaching personnel so that the States can reach the goal of properly servicing handicapped children and youth by 1980. Divisional programs which are designed to respond to this goal are four-fold in their attack in that they must provide: (1) classroom supervisory, consultative, and administrative personnel for State and local special education programs; (2) personnel for higher education institutions responsible for preparing administrative and classroom personnel; (3) paraprofessionals for special education programs; and (4) training for regular educators to work with handicapped children.

B. 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 traineeships were granted to 484 individuals who became college and university professors while 208 others became State and local special education leadership personnel.

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.

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 appropriated funds have been used as stipends for students as well as to support colleges, universities, and States; education agencies. Since P.L. 85-926 was passed in 1958, approximately 32,000 traineeships have been awarded to individuals preparing to work with mentally handicapped children. This included both short-term and full academic year awards.

State Education Agencies have received approximately $6,000,000 in recent years to provide short term training in their respective states. This money has been largely used to provide for inservice training of special educators.

Training Awards in the Area of Mental Retardation Fiscal Years 1960 through 1975

Fiscal Year	Number of Traineeships	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	6,171	200	55	10,391,341
1971	4,909	207	55	8,955,355
1972	5,100	210	56	8,955,355
1973	4,830	215	56	8,476,181
1974	5,835	225	56	10,240,450

This program 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 300 institutions requesting funds in the area of mental retardation indicates that more than 170 of them have on their faculties former trainees of the program.

Under current awards policy, which gives more authority to universities to administer their own programs according to local needs and requirements it is difficult to report discrete number of teachers being trained for mental retardation. However, it is our best judgment from review of

proposals received that the number of teachers being trained for mental retardation has not diminished and funds allocated have not been reduced. Emphasis is now being placed on training teachers to serve the more severely retarded child. Institutions are changing training programs to fit this demand.

C. Cooperative Activities

The Division of Personnel Preparation 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:

University Affiliated Facility Program

The Division of Personnel Preparation in cooperation with the Division of Developmental Disabilities, Rehabilitation Services Administration (SRS) provided support monies to special education components in university-affiliated facility programs for fiscal year 1974. The extent of the Division's support ranged from approximately $20,000 to $30,000 with a total expenditure of $501,000.

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 institutions receiving support through this program for recent years were: Georgetown University; University of California at Los Angeles; Johns Hopkins University; Indiana University; University of Miami (Florida); Ohio State University; University of Cincinnati; University of Tennessee (Memphis); Children's Hospital (Harvard); University of Oregon; University of Alabama (Birmingham); Utah State University; University of Wisconsin; Georgia Retardation Center (Georgia Department of Public Health); University of Kansas; the University of Michigan; University of North Carolina.

D. Special Projects

The Special Projects program in the Division of Personnel Preparation, Bureau of Education for the Handicapped, is designed to provide an opportunity for conceptualizing and implementing on a trial basis, approaches to personnel preparation for the education of the handicapped children which are basically new or which are significant major modifications of existing personnel preparation programs. Special Projects are designed to encourage and facilitate innovative approaches to the solution of major training problems.

Currently there are approximately 50 operational Special Projects funded by the Division of Personnel Preparation. Approximately one-third of these projects are concerned with the preparation of personnel to educate retarded children. Most of these projects are primarily concerned with the most severely handicapped. During fiscal year 1974 approximately one-third of the 5.8 million dollars invested in these projects was specifically targeted for the mentally retarded.

E. Future Goals

The goals of the Division of Personnel Preparation are to:

1. Increase the number and quality of personnel for education of the handicapped with special attention to early childhood education, vocational education, the urban and rural poor, paraprofessionals and to train regular classroom teachers to teach the handicapped.

2. Increase the amount and quality of technical assistance to agencies and institutions training professional personnel.

3. With State departments of education and institutions of higher education effect cooperative planning for the training of personnel in special education.

4. Develop a systematic data collection program upon which to monitor current efforts and to base future efforts.

Research

A. Purpose

The Research Program of the Bureau of Education for the Handicapped 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.

B. History

This program, now administered by the Research Projects Branch, was initiated during fiscal year 1964 with appropriation of one million dollars authorized under Title III, Section 302 of Public Law 88-164. This authorization has been continued, through the ensuing years and the scope and flexibility of the program have been expanded. In April, 1970, the various acts of legislation that pertained to research were incorporated into P.L. 91-230, Education of the Handicapped Act. The latest Act, P.L. 93-380 provided for authorization through fiscal year 1977. An increasing proportion of research funds have been allocated to projects which impact more generally on the education of handicapped children. In general, such "non-categorical" projects have tended to equal or exceed the amount of activity directed specifically at the field of mental retardation, and may be assumed to have virtually as much an impact on programming in the field of mental retardation as do those projects which relate to problems specific to the mentally retarded.

C. Impact on the Problem of Mental Retardation

It is frequently difficult to assess the direct impact of research activities on educational programming since the lag between the discovery of new knowledge and consequent changes in educational practices obscures the relationship. However, a number of suggestions regarding program impact are available. As of the end of 1974, supported projects had resulted in the distribution of over 500 project reports relating to education of the mentally retarded through the ERIC system, and at least an equal number of publications in professional journals. In addition, validated curriculum materials designed specifically for mentally retarded groups have been developed and are now available in the areas of

social learning, arithmetic, science, physical education, and self help skills. Special education instructional materials centers and regional resource centers for the handicapped which began as development/demonstration projects supported through the research program have now become institutionalized service operations providing services to the mentally retarded as well as other handicapped populations.

D. Current Activities

A number of research and research related activities relevant to the education of mentally retarded children are currently being supported by the Research Projects Branch. A major applied research program is involved in a series of studies relating to the effects of teacher behavior on pupils, and on ways of establishing more effective teacher behaviors. Another major program is investigating methods of optimally matching learning characteristics of retarded children with various teaching methods and environments. Development of additional specialized curriculum materials for the mentally retarded continues with particular emphasis on development of new materials for severely retarded children.

Additional efforts of a more general nature also have particularly important implications for the retarded. Among the most important projects currently being conducted is an investigation of reintegration of handicapped children into regular education programs. A second major effort involves a series of eleven demonstration projects involved in the investigation of techniques for integration of a wide variety of community services available to retarded and other handicapped children.

E. Future Goals

In order to stimulate more effective programming for handicapped children the research and development program is structured to link research and research related activities more directly to the support of special education services. Major areas of emphasis are :

1. Assessment of the effectiveness of special education curricula and procedures,

2. Development of new curricula, materials, and techniques,

3. Encouragement of the broadest possible diffusion, utilization, and implementation of effective procedures.

Of particular importance in the area of mental retardation are: continued attention to development of curriculum and materials, investigation of the effects of integrating retarded children, and increased attention to the problems of severely and profoundly retarded children. Across all these activities attention will be concentrated on problems of early education and career education for the retarded.

RESEARCH PROJECTS IN MENTAL RETARDATION

YEAR	NUMBER	AMOUNT
1964	9	$238,270
1965	14	520,905
1966	39	1,110,089
1967	32	1,084,429
1968	31	1,608,076
1969	29	2,184,921
1970	16	1,601,709
1971	10	4,413,863
1972	7	2,204,723
1973	10	3,114,625
1974	15	2,624,133
1975 estimate	15	3,000,000
1976 estimate	15	3,000,000

Other

Program funded by Title I, Library Services, of the Library Services and Construction Act (LSCA) benefit many mentally retarded children and adults whether they live in State of local residential facilities or in private homes. This program is administered by the Office of Libraries and Learning Resources in the Bureau of School Systems. Under this State administered matching program, libraries are established and improved in residential institutions operated or substantially supported by the State; specialized materials and services are provided to persons who, because of physical handicap, are unable to read or use conventional printed material; and public library services are extended and improved in areas where they are inadequate.

It is difficult to estimate the number of public library programs reaching the mentally retarded because they are often part of broader services such as Library Outreach summer Reading Programs for Children, etc. There is growing evidence, however, that public libraries are developing collections and programs for mentally retarded persons who visit the library individually or in groups, and are taking services to those who do not come to the Library.

In 1974, sixty-three of the approximately 150 eligible State institutions for the mentally retarded received special LSCA, Title I grants for the improvement of library services to residents. In addition, all the eligible institutions benefited indirectly, at least, by the provision of services by State and public libraries through such activities as interlibrary loan, film circuits, talking books and training and consultative services.

One of the outstanding examples of special LSCA projects for the mentally retarded is:

Montana - The Montana State Library established a branch library within the Boulder River School and Hospital for mentally retarded persons. The School contributed the physical space and the utilities; the State Library uses LSCA funds to provide a full-time professional librarian and a collection of books, educational toys, games, and audio-visual materials selected for maximum developmental and recreational use by some 600 seriously retarded youngsters, as young as four years old. Moving from temporary quarters in the School basement, the Library opened in early 1973 and has been a source of pride and a scene of good happenings to all involved. To illustrate: a browsing section of the Library is used by 60 foster-grandparents to read to their "grandchildren", to introduce learning games, toys, and to enjoy their close and supportive relationship, compounding the impact of both Federal programs for the benefit of the retarded youngsters in Boulder.

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PUBLIC HEALTH SERVICE

Health Services Administration
Bureau of Community Health Services

Maternal and Child Health

Maternal and Child Health service programs designed to meet the needs of children with mental retardation or developmental delay have demonstrated continued growth in three major areas: 1. Basic health and supportive services; 2. Preventive services; and 3. Training of personnel to deliver these services.

Through programs supported with previously earmarked portions of MCH and CC funds, States are demonstrating both the unique and specific contributions which can be made on a State and local level in evolving balanced services for retarded children and those handicapped children who show a developmental lag.

Through the mechanism of basic formula and special project grants, new and better ways of meeting need and delivering care have been demonstrated. Because of the demonstration nature of the programs, they do not provide total services for an area or community.

I. Basic Health and Supportive Services

Maternal and Child Health Services

Section 501, Title V, Social Security Act, authorizes annual formula grants to the States to extend and improve health services for mothers and children, especially in rural areas.

These are basically programs to improve nutrition, prevent ill health and infectious disease, safeguard the period around pregnancy, and minimize health hazards by identifying them as early as possible. State maternal and child health programs included some of the following services for fiscal year 1973:

- Maternity nursing services to 526,945 mothers.
- Family planning services to 1,107,721 women.
- Prenatal and postpartum care in maternity clinics for 335,200 mothers.
- Nursing services to 3,340,914 children.
- Dental treatment for 1,676,204 children.
- Vision screening for 8,519,712 children.

. Audiometric testing for 5,846,129 children.

. Well child conferences, serving 1,511,191

Crippled Children's Services

Section 501, Title V, Social Security Act, authorizes annual formula grants to the States to find children who are crippled or who are suffering from conditions leading to crippling, and to provide them with medical, surgical, corrective and other services.

A total of 512,881 children received physician's services and 80,932 received hospital inpatient services under State crippled children's programs in 1972.

More children in every age group, from infant through adolescent, received services in 1972.

Congenital malformations accounted for 21 percent of all conditions noted, and more than 19 percent of the children served were reported to have multiple conditions, including mental retardation.

Clinical Services

Clinical services for mentally retarded children operating in all but two States include diagnosis, evaluation of a child's capacity for growth, the development of a treatment and management plan, interpretation of findings and counseling of parents, and follow-up care. Mental retardation clinic services were provided for over 75,618 children, and 363,107 visits made to 166 clinics supported by MCH funds during FY 1973.

Children are being seen at these special clinics at an earlier age as a result of multiple screening procedures carried out by the State maternal and child health programs. 40.2 percent of the new patients seen in these clinical programs were under 5 years of age; 39.8 percent were 5-9 years old; 15.4 percent were ages 10-14.

New patients numbered 31,891. These clinical programs fulfill a major function of "unlabeling" children referred as mentally retarded. Among children classified in FY 1973, 10,786 were found not to be retarded.

Multiply-Handicapped Children's Clinics

Ten specialized clinical programs for multiply-handicapped children are providing comprehensive services for children with a multiplicity of handicapping conditions including mental retardation. They continue to serve as models for the type of staffing and services required to meet the total needs of children in a single setting.

Genetics Program

Twenty Projects supported with CC funds provided cytogenetic and biochemical laboratory services as extensions of clinical services at selected medical centers. Newer and more efficient laboratory techniques adapted for service delivery from research programs are being demonstrated in the provision of genetic counseling to families served in these centers.

II. Preventive Services

Maternity and Infant Care Projects

Section 508, Title V, Social Security Act, authorizes grants for projects to help reduce the incidence of mental retardation and other handicapping conditions caused by complications associated with childbearing and to help reduce infant and maternal mortality by providing necessary health care to high-risk mothers and their infants.

Fifty-six Maternity and Infant Care projects, located in 34 States, the District of Columbia and Puerto Rico were operational in fiscal year 1973. While more than 60 percent of the Maternity and Infant Care projects serve cities of 100,000 or more, projects are also located in rural and urban-rural populations in such States as Alabama, Georgia, Florida, Arkansas, Idaho and others. All the projects serve localities which have shown higher infant and maternal mortality rates than the Nation as a whole.

There are approximately 1,163,000 admissions for maternity care and 833,000 for family planning services.

Inborn Errors of Metabolism

Phenylketonuria (PKU), an inborn error of metabolism has in the past been responsible for 1 percent of the population in the State institutions for the mentally retarded. By detecting families with the condition and by providing young infants with the condition with a special diet, mental retardation usually can be prevented. BCHS works with State health departments in developing the necessary laboratory facilities and assisting States to provide special diets and follow-up services for these families.

Approximately 90 percent of the newborns in the 50 States and the District of Columbia were screened. This effort by the States turned up approximately one confirmed case for every 16,000 live registered births.

BCHS is continuing to support a study of the clinical application of screening tests to detect galactosemia, maple syrup urine disease and histidinemia. Support is also being given to studies of new approaches to broader screening methods which would make available a battery of automated tests for detecting metabolic diseases. In the meantime the PKU collaborative project involving 16 treatment centers throughout the country is attempting to determine when and how children with PKU, who have been on treatment since birth, can be discontinued on the special diet without harmful effects.

Lead Poisoning

BCHS Children and Youth projects are continuing to screen their populations for lead poisoning as a part of their health maintenance program. Earlier detection and treatment is being achieved. Of 49 projects that responded to a survey on the problem of lead poisoning, 51% stated that this continued to be a major public health problem among their patients. Two projects were routinely testing all of the children seen by them, 12 projects were testing all children under 6 years of age, and 20 tested children considered high risk for lead poisoning. 18 of the projects reported a total of 922 children treated for lead poisoning for the twelve month period ending September 30, 1972. At the same time, screening programs are finding some children with elevated blood levels who do not live in dilapidated housing and do not have a history of pica.

Rh Factor

State maternal and child health programs reported continued progress during fiscal year 1973 in the prevention of hemolytic disease of the fetus and newborn through the use of anti-Rh immune globulin. An increasing number of States are utilizing MCH formula funds to provide immune globulin to women needing it.

With the liberalization of abortion laws, it will become critically important that the utilization of anti-Rh immune globulin also be made available to these patients.

Rubella

Many of the babies born with birth defects resulting from the rubella outbreak of 1964 and 1965 and showing evidence of mental retardation or other handicaps continue to be cared for under special clinical programs

for retarded handicapped children. The President's Committee on Mental Retardation estimates that the nation is now paying $140 million for the care and treatment of these child victims. Outbreak of rubella in isolated communities were reported during 1973 and States are encouraged to use MCH funds to complete the immunization of children against rubella as part of the national campaign spearheaded by the Center for Disease Control.

III. Training

Under Section 511, Title V, Social Security Act, grants are made for the training of personnel in health care and related services for mothers and children, particularly mentally retarded children and children with multiple handicaps.

Training activities are also supported by funds authorized under Sections 503 and 504 of Title V for projects which may contribute to the advancement of maternal and child health and crippled children's services.

University-Affiliated Centers

The program designed to provide comprehensive multidisciplinary training of specialists who will work with the handicapped and retarded is based on a concept of multi-agency funding and multi-departmental university participation. It had its beginning in 1963 under P.L. 88-164, which authorized Federal support in the construction of facilities to house such training efforts. At many of the universities that applied, MCH was already involved in the funding of clinical services.

The University Affiliated Centers have developed effective programs of prevention, treatment, and rehabilitation. Each offers a complete range of clinical services through a core faculty representing at least 20 professional disciplines, who work together to demonstrate a continuum of services for the handicapped and to train a variety of students. While all basic objectives are similar, each center is shaped by its staff, location, physical plant, and the specific disciplines and university departments that are involved in its operations.

The Association of University Affiliated Facilities has reported that the 32 operating programs trained 50,000 students at various levels during FY 1973. This included 552 fulltime students from over 25 disciplines who spent at least 500 hours in training. Of this group MCH stipends supported 318 fulltime students in 20 of the programs represented in this association.

Indian Health Service

I. Preventive Services

A. Prevention of Organically Based Mental Retardation

The best prevention of organically-based mental retardation is an active, comprehensive, high quality program of prenatal, intrapartum and postnatal care for mothers and infants. The Indian Health Service continues to put high priority on its total services for mothers, infants and children by encouraging more and better prenatal care, better nutrition, full use of family planning services and counseling. Deliveries are provided at 47 hospitals, and outpatient pre- and postnatal care and counseling are available at all facilities.

Better nutrition of pregnant mothers, and of their infants, reduces organically-based mental retardation in infants, as does more complete prenatal care which allows earlier detection and correction of medical conditions which can harm the unborn infant.

Genetic counseling is provided when indicated, and to promote responsible parenthood family planning services are provided. These services include assistance with problems of infertility as well as with the more common problem of spacing pregnancies.

The Indian Health Service also continues its efforts to increase the number of infants and children immunized against measles and rubella, to reduce the number of children with brain damage and congenital anomalies that result from measles encephalitis and from maternal rubella during the first trimester of pregnancy.

The Nurse-Midwifery program continues to increase the services available for better care of mothers and children.

Services for mentally retarded patients are coordinated with state and local health departments by Area Offices and Headquarters, Indian Health Service. Assistance and cooperation of Regional Offices, through grant-in-aid funds, makes possible regional planning of programs and services for the mentally retarded.

B. Prevention of Functionally-Based Mental Retardation

As part of the ongoing comprehensive health program on Indian reservations, the Indian Health Service is working cooperatively with Headstart programs and Bureau of Indian Affairs schools and personnel in all areas in efforts at prevention, detection, treatment and planning rehabilitation for children with functional mental retardation. The model dorm program jointly sponsored by Indian Health Service and the Bureau of Indian Affairs continues as a successful mechanism in preventing functional mental retardation in early school age children.

II. Professional Preparation

A. Indian Health Training Program

The Indian Health Service continues to support physician residency training in pediatrics through Out-of-Service programs. Such training includes instruction in prevention, diagnosis, treatment and rehabilitation of mental retardation.

The Indian Health Service continues to provide both In-Service and Out-of-Service training for nursing and auxiliary personnel, including community workers (CHR's), to ensure continuity of service from hospital to homes.

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

Center for Disease Control

Lead-Based Paint Poisoning Prevention

Approximately 6,000 children per year suffer neurological damage from the ingestion and absorption of lead.

Conditions conducive to increased lead absorption occur when children living in deteriorating housing ingest peeling or chipping lead-based paint.

Through project grants and technical assistance, the Center for Disease Control Childhood Lead-Based Paint Poisoning Prevention Program is directed towards detecting, treating, and abating lead-based paint hazards in the home environment. During FY 1974, 41 project grant communities tested 371,955 children for evidence of undue lead absorption of whom 16,228 had elevated blood lead levels and 3,801 required chellation treatment.

Immunization Programs

Since the live rubella vaccine was licensed in 1969, The Center has awarded project grants to State and local health agencies to assist them in developing and conducting immunization programs to prevent and control the spread of rubella; thereby reducing the occurrence of congenital rubella syndrome and its complications such as mental retardation and blindness.

Fear of an extensive rubella epidemic in the early 1970's prompted support for a rubella immunization program which could rapidly immunize large numbers of susceptibles. Since grant support was initiated in 1969, over 48 million doses of rubella vaccine have been administered to such a large group of susceptibles so soon after its licensure.

Results of these immunization efforts have been dramatic. Not only has the predicted rubella epidemic not materialized, but reported cases of rubella have declined steadily (56,552 in 1970 to 11,836 in 1974). It is estimated that as many as 3.0 million cases of rubella and 30,000 cases of congenital rubella syndrome have already been prevented. However, an estimated 5-6 million preschool age children remain unprotected against rubella.

National Institute of Neurological Diseases
and Stroke

Neurological disorders caused by biological factors account for a large percentage of the mentally retarded. The biological factors include any which cause physical or chemical damage to the brain or nervous system--a virus, a poison, an accident, or a hereditary factor such as an error in metabolism or a missing gene. Scientists also are seeking any unknown causes of damage to the brain before, at, or around the time of birth. The National Institute of Neurological Diseases and Stroke (NINDS) studies the biological factors known or suspected to be related to mental retardation.

The NINDS supports a large number of research projects aimed at clarifying metabolic derangements leading to central nervous system damage and at identifying specific injuries to the brain or other parts of the nervous system. The programs deal specifically with neurological disorders of early childhood including cerebral palsy, birth injuries (both discussed in a separate report), Tay-Sachs and other lipid storage diseases, kernicterus, phenylketonuria, mongolism, spina bifida, and hydrocephalus. These disorders are often accompanied by mental retardation.

Researchers sponsored by NINDS also seek answers to fundamental biological, biochemical, or molecular processes critical for complete understanding of mental retardation. Such studies are of more long-term importance for real solutions (prevention, cure, or treatment) of disease than simple alleviation of symptoms.

Collaborative Studies Related to Children

One of the Institute's most significant research projects relating to mental retardation is the collaborative study of the development of children. The NINDS worked with 14 cooperating institutions to conduct the Collaborative Perinatal Research Project. This Study made and recorded observations of some 58,000 women and their pregnancies to investigate the prenatal, perinatal, and postnatal factors of child development. Most of the surviving children have been given a series of tests through age eight.

As a result of the Study, scientists have learned such things as the distribution of blood antibody levels, the consequences of high bilirubin levels in nursery age children (which produce jaundice and can cause brain damage), the distribution of physical and intellectual measurements, and the frequency of certain abnormal conditions. Researchers have found low birth weight to be a very important factor in stillbirths, in neurologic abnormalities, and slow intellectual development.

Since the Study began in 1959, over 500 scholarly papers have been written on the findings. As analysis and interpretation of data are completed, monograph reports will be published in book form on cerebral palsy, mental retardation, communicative disorders, minimal brain dysfunction, congenital malformations, birth weight gestational age relationships (prematurity), and neuropathology, general pathology, and placentology.

Research Grant and Training Program

The NINDS supports research on the developing nervous system and its disorders which has the potential for yielding important information relating to the problem of mental retardation, the most devastating consequence of these disorders. Through its research training grant programs, the NINDS has stimulated a number of individuals to enter research careers in the fields of child neurology, speech pathology, and audiology. These specialists are now in the forefront of those seeking new information on the early diagnosis and treatment of mental retardation and the accompanying impairments, especially problems of communications.

Genetic Disorders Related to Retardation

There are over a thousand genetic disorders that afflict man, and among them are the inborn errors of metabolism, which are of special interest to NINDS searchers. Many of these cause severe mental retardation or early death. Of the 200 known, 40 can now be detected before birth by tests of the amniotic fluid obtained by amniocentesis from the pregnant mother.

Although only a few of these disorders are treatable, many of them can be prevented through genetic counseling. Standardization and wider use of amniotic fluid tests during the past year have improved prenatal diagnosis and carrier detection, and have also led to improved diagnosis of the nine known lipid storage diseases. These disorders often cause severe mental retardation. Pioneering biochemical research on metabolic pathways by NINDS-supported scientists has made it possible to pinpoint the specific enzyme defect in all nine lipid storage diseases, including Tay-Sachs Disease. Such studies have already provided clues to possible treatment for some of the disorders while other research is aimed at improving prenatal diagnosis and carrier detection tests. Such improvements combined with genetic counseling could lead toward eradication of these inborn errors of metabolism.

Retardation Caused by Hydrocephalus

Mental retardation often follows hydrocephalus (an increase in the size of the normally fluid-filled cavities and cisterns within the brain causing brain damage) and brain tumors in childhood. Scientists are working to develop appropriate surgery and drug treatment and are using antitumor materials tagged with radioisotopes to improve chemotherapy. Tests were conducted last year and will continue this year on the use of a tomoscanner and will be supplemented by use of the newly ordered EMI-scanner to aid scientists in detection of brain tumors.

In Fiscal 1974, the NINDS supported 158 studies on neurological disorders of early life, a large number of which are accompanied by mental retardation at a cost of $9.7 million. Intramural and collaborative programs, including the Perinatal Project, numbered 60, at a total cost of $4.8 million.

National Institutes of Health

National Institute of Child Health and Human Development

The National Institute of Child Health and Human Development (NICHD) supports research into the biological, behavioral and social processes which contribute to or influence the development of retarding disorders. Of primary concern are basic studies into the causes and means of preventing mental retardation. The Institute employs research grant support, creates and supports special research facilities and resources, disseminates scientific and public information, and provides contract support of research to accomplish its specified goals. The Institute's research programs and resources provide research knowledge and understanding applicable not only to the problem of mental retardation but to other closely related developmental disabilities as well.

Research into the causes, means of prevention, and methods of amelioration of mental retardation serves many of the research requirements of the developmental disabilities including cerebral palsy, epilepsy, autism and special learning disabilities. With the exception of special learning disabilities, mental retardation is frequently associated with the other developmental disabilities.

These conditions are a frequent consequence of reproductive casualty resulting from disorders of pregnancy, complications of birth, and maternal ill health. The Institute, because of its assigned responsibility for research in maternal and child health, has a major research concern for these disorders. All of the Institute's research programs make significant contributions concerning these issues.

Many of the research accomplishments supported by the NICHD have been achieved in the Institute's 12 Mental Retardation Research Centers. These interdisciplinary Centers, located throughout the country, are uniquely capable of investigating the complex problems of mental retardation and related developmental disabilities, training of future scientists, and applying research findings to service. The close working association of the Centers to the University-Affiliated Facilities (10 of the 12 Centers are directly related to the UAFs administratively) which are concerned with the full array of developmental disabilities, further expands their research capabilities. Together, these Centers represent a major national resource for research aimed at finding the means of prevention and amelioration of mental retardation and related developmental disabilities.

Prevention

Lowering the incidence of Down's syndrome (mongolism) is a primary Institute goal. Many separate investigations supported by the Institute and other sources have contributed to research advances which have made possible the diagnosis of mongolism during the early months of pregnancy. Collectively, these advances across the broad fields of genetics, cytogenetics, and obstetrics have established the technology for service programs of intrauterine diagnosis. Prevention of mongolism and other genetically determined disorders is now

possible through utilization of these new diagnostic capabilities. Provided with an accurate diagnosis during early pregnancy, and assisted by genetic counseling, the parents of an abnormally developing fetus can elect termination or continuation of the pregnancy.

Research investigators have shown that the incidence of mongolism rises with increasing maternal age. The chances of giving birth to a child with mongolism is about five times higher for women over 35. It is over 35 times more frequent for women 45 or older.

These developments prompted the Institute to initiate a national health education campaign aimed at reducing the incidence of mongolism. Three pamphlets were developed and distributed to the medical and health related fields which might be expected to assist the Institute in this effort. These pamphlets were "Facts About Mongolism for Women Over 35," "Antenatal Diagnosis and Down's Syndrome," and "What is Mongolism?" The Institute also sponsored a science writers seminar in an effort to bring to the public, through the popular press, the important epidemiologic and genetic information which bears significantly on the incidence and prevention of mongolism.

Continuing research at the University of Colorado's Mental Retardation Research Center into the relationship of nutrition and intellectual development and brain growth indicates the issues are more complex than previously thought. A study of the effects of wheat as a sole protein source during pregnancy and its effect on the brain development of rats demonstrated that fortification with lysine or lysine plus threonine markedly improves brain growth. These findings have international importance because of the frequent use of lysine deficient staples in developing countries. These findings are augmented by the nearly one dozen other studies supported by NICHD in experimental animals or intervention efforts with undernourished children and pregnant women throughout the world. It is increasingly apparent that the potential behavioral and intellectual consequences of long-term malnutrition will require combined nutritional, educational, and public health intervention to be maximally effective.

An examination of children in Head Start who fell below the third percentile in height and weight indicated deficiencies in zinc, vitamins A and B, and folic acid. This suggests the need for careful nutritional evaluation of children with these physical traits.

Micronutrients in the diet, such as chromium, are assuming increasing importance as factors in development and disease. Chromium deficiency has been identified as causative or contributory to glucose intolerance of children suffering from protein-calorie malnutrition and to the onset of diabetes in middle-aged and elderly persons. Low birth weight may also be associated with this deficiency. Further confirmation of these findings may require modification of current dietary practices and food processing techniques.

The Colorado investigators also studied the use of nutritional aides to improve the nutritional status of migrant farm children. Study results indicated little success despite the favorable ratio of aides to families and extensive professional training and support. Various speculations are advanced to account for the relatively poor outcome: immediate, pressing needs of the target population may overshadow and offset attempts to improve their eating patterns; the group may be resistant to adoption of new ideas. This study indicates that simple remedial solutions to problems of malnutrition may not be effective and that further research is needed on ways to change dietary habits.

Amelioration

Social environmental factors in the development of disadvantaged children and methods for remediating their effects constitute a major research effort. Investigators at the University of Kansas' Mental Retardation Research Center have developed a Responsive Teaching Model from research with such children which is now being applied in schools in nearly every state in the nation. The model, which is a scientific behavior management system, has been extended to the home and other settings with significant impact on social and academic behaviors of normal and handicapped children. The utilization of these techniques by parents and teachers should permit more developmentally disabled children to remain in their own homes and communities.

The Kansas investigators have also developed a successful program to allow severely and profoundly retarded children to communicate without the use of speech and language. Children use geometric forms of various shapes as words and morphemes without requiring spoken responses. Such children are generally regarded as poor candidates for language training. Their potentials in this area are being further enhanced by the use of a motor imitation manual which serves as a basis for training in language skills.

Center investigators at the University of Wisconsin have studied the effect of impulsiveness in retarded children. Study results indicate that learning does not take place even after weeks of training and that discrimination performance is poor under impulsive behavior. The introduction of a simple five second delay period dramatically increased receptive language performance, suggesting that in many situations learning ability of the retarded has been vastly underrated. The study points to the need for more research on optimal training and testing procedures.

Wisconsin investigators also have compared interactions of normal and retarded mother-child pairs in linguistic and social dimensions and the effectiveness of training to change the maladaptive and inappropriate communications noted in the mothers of retarded children. These interactions tend to deteriorate as the child grows older. Training of parents with children aged 18 months to 5 years has resulted in improved use of language and social competence in the child.

An automated method for introducing severely retarded children to reading comprehension has been developed at the E. K. Shriver Center at Fernald State School. Children are taught to associate dictated words with pictures and then to printed words. They can then associate pictures and printed words, thus learning a basic reading vocabulary. These preliminary steps to reading are accomplished by use of a teaching machine; the automated methods identify candidates for reading instructions who would otherwise largely be overlooked.

Organizational and other elements affecting the quality of care in institutions is being studied by investigators at this same Center. Unitization--the establishment of quasi-autonomous living units in large formerly centralized institutions--is one of the elements under study. Findings in one facility indicate only minor shifts toward resident orientation through such administrative change and that practices are still largely characterized by rigidity in routines, depersonalization and social distance between residents and staff. It has also been noted that IQ level of residents is strongly associated with the quality of care provided despite the higher staff ratios afforded the more severely disabled. This suggests the need to identify the personality traits of caretaker personnel conducive to resident-oriented care practice.

Alcohol, Drug Abuse, and Mental Health Administration

Research on mental retardation has been supported by the National Institute of Mental Health for over a quarter century. Although major responsibility for mental retardation was shifted to other Federal agencies a few years ago, the Institute's program continues to support and fund selected studies in the area. Some research projects deal directly with mental retardation many of these projects were started several years ago. Others have indirect or potential significance for retardation.

Several studies are related to the prevention of mental retardation, especially environmentally induced mental retardation among children and youth. An effort to prevent cognitive defects is being carried out in the homes of disadvantaged children before they reach the age of 3. These investigators are attempting to alter the mother's teaching style, language style, and management procedures when necessary. In another preventive study, investigators in Oregon are identifying interaction patterns among families with retarded children, to determine how negative and positive behaviors are communicated, and how they alter behavior responses among members.

Recognizing the complex interrelatedness between mental retardation and emotional development, other researchers using a school-based model are testing the ability of teachers to promote self-awareness and interpersonal functioning among their pupils, while at the same time decreasing pathological manifestations.

Early detection and accurate classification of retardation have been found to be key factors in successful treatment and rehabilitation. NIMH is supporting research to assess the capabilities of low-IQ children in order to better differentiate among them. Besides measuring learning potential among the educable mentally retarded, it will develop another measure of learning potential for use with primary grade children; then it will initiate a longitudinal study of young nonlearners--their trainability in memory, learning, and speech functioning. Another study is comparing the emotional responses of mentally retarded children with those of normals to gain a more accurate perspective of the range and variability of emotional behavior among retardates. NIMH staff members, meanwhile, have developed a preschool test using prepositions as an instrument for screening children between ages 3 and 5 for mental retardation. Still being validated, the test has been used with promising results in Head Start classes and on disadvantaged populations. At present, it is being used on about 700 Maine youngsters to detect developmental lag, and preliminary reports are promising.

In another project, the investigator is developing methods for differential diagnosis of reading disability, on the assumption that not all "retarded" readers are in the same category. This project is the outgrowth of earlier work on bisensory memory and audiovisual matching.

Three separate, but related, studies on the social and behavioral aspects of mental retardation in school children were done by a California investigator. This research, which has produced over 200 articles, chapters, and volumes that

have been widely disseminated has been supported by NIMH for 7 years. It has resulted in a model for reporting biannual evaluation of hospital patients and changes in their social and behavioral characteristics. Another long-term investigation has explored the learning and transfer processes in retarded children.

Another area of NIMH support has been the training of mental health personnel in special treatment approaches and techniques found to be effective in rehabilitating mentally retarded children. One example is a study in Kansas which provides intensive training in special clinical techniques relevant to retarded children and youth, with emphasis on family therapy and effective utilization of community resources.

Longitudinal investigations of the epidemiology of impaired competence is being studied by another NIMH investigator, while still another is trying to determine the epidemiology of exceptionality in school children. The latter considers children "exceptional" if they are educationally handicapped, gifted, mentally retarded, emotionally disturbed, or physically handicapped. She plans to relate clinical characteristics, such as IQ, adaptive role behavior, and physical disabilities, to modes of sociocultural characteristics for Black, English-speaking Anglo, and Mexican American children.

Over the past years it often has been pointed out that classifying children, especially exceptional children, according to diagnostic categories may have deleterious effects. The "labels" or names may have unfavorable connotations and imply predictions of future behavior. Such labeling might be particularly important in some kinds of recordkeeping, as, for example, cumulative records in school system. The NIMH has sponsored a significant study of this problem, and a book "The Futures of Children: Categories, Labels, and Their Consequences" has been published.

Biological studies are also underway that are directly or potentially relevant to mental retardation. For example, one researcher is studying the relationship between abnormal metabolism and mental disease including, among other subjects, infants with phenylketonuria (PKU) and mentally retarded individuals; emphasis is on identification of abnormal chemical reactions in mentally ill and retarded individuals, especially the metabolism of aromatic acids in tissues and urine. Another study is investigating the psychophysiology of sleep and dreaming in mentally handicapped, as well as other, individuals. Another basic research project is concerned with the structure, distribution, and metabolism of acid mucopolysaccarides in nervous tissue; this work should lead to a better understanding of the origins of central nervous system abnormalities, such as mental retardation.

The Institute's research program in mental retardation while not currently extensive, covers areas of investigations with important relevance to the field. Especially in basic research efforts, ranging from studies of the effects of environment on behavior to analysis of nervous system tissue, knowledge is accumulating that will result in a more thorough understanding of the phenomena of mental retardation, and of ways to prevent it.

HEALTH RESOURCES ADMINISTRATION

Mental Retardation Construction and Consultation Activities in the Division of Facilities Utilization (Hill-Burton Program), Bureau of Health Resources Development

Mental retardation facilities have been eligible for and have received construction assistance from the Hill-Burton program since its inception 29 years ago. Up until the passage of the "Mental Retardation Facilities Construction Act" (1963) - P.L. 88-164, Title I, the Hill-Burton program was the primary source of Federal assistance for retardation construction, and administered the Act after enactment until August 1967. Since the advent of the specific construction programs for retardation facilities, the Hill-Burton program has been acting primarily as a back-up resource for construction aid. As of June 30, 1974, a total of 109 retardation projects have been assisted with $56.6 million in Federal funds since the Hill-Burton program began. Hill-Burton personnel in both the HEW Regional Offices and in the State Hill-Burton agencies have provided expert consultation to the retardation facility programs and to many retardation project sponsors or potential sponsors. Hill-Burton consultation is especially valuable where retardation services are to be provided in a comprehensive health care facility or in any combination with other health services.

SOCIAL AND REHABILITATION SERVICE

Mental Retardation

Introduction

On August 15, 1967, the Social and Rehabilitation Service was established by the Secretary, Department of Health, Education, and Welfare, to join under a single leadership income support programs for needy Americans and the social and rehabilitation programs, including services for the mentally retarded.

Four of the eight major components of the Social and Rehabilitation Service have responsibility for providing income maintenance, medical services, and social services, for the economically, physically, and mentally handicapped. These bureaus and offices administer the legislation concerned with the care and provision of services for retardates and their families in the following order: Assistance Payments Administration, Social Security Acts, Titles IV, Part A; and VI. Medical Services Administration, Social Security Act, Title XIX. Community Services Administration Title IV, Parts A and B and VI; and the Office of Planning, Research, and Evaluation, Title XI, Sections 1110 and 1115 and various other Acts or portions of Acts concerned with the health and welfare of the mentally ill or retarded. Following is a description of the Social and Rehabilitation Service's efforts on behalf of the mentally retarded.

Assistance Payments Administration

The Assistance Payments Administration has primary responsibility for grants to States for public assistance programs under the Social Security Acts, Title IV, Part A, Aid to Families with Dependent Children and Emergency Welfare Assistance; and Title XVI, Aid to the Aged, Blind and Disabled (Guam, Puerto Rico, and Virgin Islands only). It is in the disabled portion of the latter program that Federal financial participation is available to help needy individuals who also may be mentally retarded through territorially administered public welfare program.

P.L. 92-603, enacted October 30, 1972, established a national program to provide supplemental security income to individuals who have attained age 65 or are blind or disabled except for Guam, Puerto Rico and Virgin Islands. The national program became effective as of January 1, 1974, at which time the Social Security Administration assumed responsibility for making Federal payments to eligible recipients formerly carried by the States and territories under Titles I, X, and XIV. Since the Assistance Payments Administration's authority to make payments to disabled recipients expired December 31, 1973, Federal expenditures shown in the Table of Obligations are for Guam, Puerto Rico, and the Virgin Islands only starting in 1975.

Community Services Administration

The Community Services Administration has responsibility for administering the Social Services program authorized by Titles I, IV-A, VI, X, XI, XIV and XVI, and Child Welfare Services authorized by Title IV-B of the Social Security Act, as amended in 1972.

The 1974 Social Services Amendments to the Social Security Act (P.L. 93-647) establishes a new Title XX which authorizes grants to States for services to eligible individuals based on income. Except for the Commonwealth of Puerto Rico, the Virgin Islands and Guam, Title XX supersedes all previous authorizing Titles except Title IV-B and is effective October 1, 1975.

Within the broad-spectrum of services provided to eligible individuals are those directed to serving the mentally retarded. Some of the more important services extended to the mentally retarded are:

(1) Day care services which facilitate the child or adult remaining in his own home in lieu of institutionalization.

(2) Short term family foster care during periods of crisis to prevent institutionalization and long term family foster care to provide benefits of family and community living in lieu of institutionalization.

(3) Services directed at attaining entrance to institutional placement where needed and services to move individuals out of institutions where feasible.

(4) Other services such as protective services, homemaker and chore services, home management, counseling, etc., which will promote retention of the mentally retarded in their own homes and assist in the development of the individual to his maximum capacity for self-care and independence. Among these are services to expectant mothers which will help reduce the incidence of mental retardation.

The basic purpose of the Child Welfare Services program is to protect children from abuse, neglect, exploitation, or delinquency and to assure that they have opportunity for normal development. Among recipients of these services are mentally retarded children from all socio-economic groups, not just children who qualify for services under the IV-A Aid to Families with Dependent Children.

It is estimated that in FY 1976 States will expend $247,000,000 in Federal funds through the Social Services program for services for mentally retarded individuals. Child Welfare Services data on the mentally retarded are not available.

(Dollars in Thousands)

	FY 1973 1/	FY 1974	FY 1975	FY 1976
Services to Mentally Retarded.....	$214,780	$202,600	$224,900	$247,000

1/ This amount, the same as reported in the 1975 Hearings, is a preliminary actual. Actual dollars amounted to $185,928, (Source: 1973 OA-41.7(c) reports), and were used to project 1974 - 1976.

Medical Services Administration

Title XIX, known as Medicaid, provides Federal matching payments for State expenditures for health care for the poor. In FY 1974, fifty-three States and jurisdictions were participating in Medicaid (Arizona is the only State not participating; however, Arizona plans to begin its Medicaid program on October 1, 1975).

With the federalization of the adult categories on January 1, 1974, under the Supplemental Security Income (SSI) program, States are not in all cases required to provide Medicaid to all adult recipients of cash assistance under Title XVI, as was the case in the past under Titles I, X, XIV, or XVI. Limited Medicaid coverage of SSI cash assistance recipients will apply in States which, in determining Medicaid eligibility, opt to apply any eligibility criteria from the January 1, 1972 medical assistance standard which is more restrictive than the eligibility requirements for the Federal Title XVI program for aged, blind, and disabled individuals. States which retain any eligibility factor(s) from their January 1, 1972, standard which is (are) more restrictive than the Title XVI eligibility factor(s) must deduct a person's medical expenses from his income in determining eligibility. (They are not required to cover Title XVI cash assistance recipients who have higher income or resources, or who otherwise do not meet the January 1972, medical assistance standard.) As of January 1, 1974, seventeen States planned to restrict Medicaid eligibility of SSI recipients under this option.

Thirty-six States extend Medicaid coverage to all recipients of cash assistance under the SSI program. States also have the option of providing Medicaid coverage to persons receiving a State Supplemental payment, subject to certain limitations. In addition, States may still elect to cover certain medically needy persons who are eligible for help only with their medical bills and who do not receive maintenance payments.

All Medicaid services included under the State plan (mandatory services include inpatient hospital care, outpatient care, physicians' services, skilled nursing facility services for individuals 21 years of age and older, early and periodic screening, diagnosis and treatment services for children under 21, lab and X-ray services, and home health services; in addition, States may cover a range of optional services including dental care, drugs, eyeglasses, intermediate care facility services, etc.) are available to eligible mentally retarded individuals.

Effective January 1, 1972, P.L. 92-223 transferred intermediate care services to Title XIX as an optional State service and authorized the provision of intermediate care facility services in public institutions for the mentally retarded if the institution provides health or rehabilitative services and if the eligible individuals are receiving active care and treatment. To assure that the Federal dollars made available for such institutional care would lead to higher quality care and services in an improved environment, and not simply to a replacement of State dollars, the legislation contained a provision requiring the States to maintain their own fiscal effort. 35 States have responded to the new Title XIX authority by adding to their State plan coverage of ICF services in public institutions for the mentally retarded. Prior to January 1, 1972, some 17 States claimed Federal matching in the costs of care in institutions which qualified as skilled nursing home services. It should be noted that because services in the past were being provided to the mentally retarded as skilled nursing home services, the adoption of the intermediate care facility program resulted in a redesignation of facilities in some States. The result is that these facilities are able to provide services at a more appropriate level of care in instances where skilled nursing care is not medically necessary. States, however, continue to provide care for the mentally retarded in skilled nursing facilities where medically appropriate.

Total Federal expenditures for services for the institutionalized mentally retarded (including ICF, skilled nursing facilities, and inpatient hospital services) were estimated to be $300 million in FY 1973. Estimates are not available on the number of Medicaid dollars expended on all other Medicaid services provided to the mentally retarded. It should be emphasized that the Medicaid eligible mentally retarded person may receive the full range of Medicaid services, and receive them on the same basis as the rest of the Medicaid eligible population.

Estimated Federal Expenditures (in Millions)

FY73	FY74	FY75	FY76
$300	$360	$415	$480

SOCIAL SECURITY ADMINISTRATION

Purpose

The basic purpose of the social insurance programs (Old-Age, Survivors, Disability, and Medicare) 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 and to the disabled under certain conditions. This part of the program is contributory and self-supporting. Benefits are wage-related and entitlement to benefits is an earned right. In January 1974, the Supplemental Security Income Program was added to those SSA administers. It provides payments to the needy aged, blind, and disabled, is non-contributory and is financed entirely out of general Federal revenues.

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 1958, there have been seven general benefit increases in recognition of the fact that prices and wages have gone up. In 1972, a section of P.L. 92-336 provided for an automatic benefit increase when the cost-of-living rises by 3 percent or more. Effective January 1974, payments under the Supplemental Security Income Program began to qualified aged, disabled, and blind persons, including the mentally retarded.

Economic Impact

Under Title II Programs (Old-Age, Survivors, and Disability)
Mental deficiency is a major factor in more than 72 percent of cases involving dependents or survivors who have been continuously disabled since childhood. In fiscal year 1974, an estimated 230,400 mentally retarded adults disabled in childhood and retarded workers received $298.08 million in benefits.

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 social security insurance 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 57 percent of the childhood disability beneficiaries are age 35 and over and 32 percent of them are age 45 and over.

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.

Under Title XVIII

Medicare benefits 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 or over who has contracted an illness or suffered an injury is, like any other person in this age group, protected under the Medicare program. (However, the Medicare program does not provide coverage of non-medical care such as personal care, vocational training, etc.) Beginning July 1, 1973, Medicare benefits were also extended to social security disability beneficiaries, under 65 years of age, who have been receiving disability benefits for 24 consecutive months.

Under Title XVI

An estimated 310,000 retarded individuals who are not entitled to benefits under the Title II Disability Insurance Program were receiving payment under the Supplemental Security Income Program by the end of fiscal year 1975.

Activities and Achievements

Since 1970, the Social Security Administration has conducted biennial on-site reviews in State mental hospitals and schools for the retarded. The program focus is an in-depth examination of the way in which these institutions are managing social security benefits on behalf of patients who receive their checks through an institutional official serving as "representative payee."

The observations and conclusions resulting from a State review are, after analysis, communicated to the State Commissioner for his use in the development of improved practices in the State's system. Findings also serve as a basis for SSA program and policy evaluation. The on-site approach is expected to strengthen relationships with the States, improve their understanding of their responsibility for optimum use of benefits when serving as representative payee, and open new channels for the discussion of problems and practices affecting the well-being of all beneficiary-patients in State mental institutions.

SSA has participated in the program to employ the mentally retarded since its inception in 1964. It has also tried to generate interest in the program by private employers and other Federal agencies. In SSA retardates are successfully performing in such positions as mail and file clerks, messengers, operators of printing, xerox, card reader machines, and key punch machines. The SSA experiment with the color coding of file cabinets and cartridges of microfilm has proven highly successful in broadening the employment opportunities for retardates to an area of work which requires a very high degree of accuracy. The retardates have performed their duties in an excellent manner.

The Social Security Administration has published a leaflet entitled If You Become Disabled. A number of others are in stages of preparation or revision.

In cooperation with the Bureau of the Census, the Social Security Administration conducted surveys in 1971 and 1972 of noninstitutionalized adults who had been reported as disabled in the 1970 Census or had become disabled since the 1970 Census. The data collected included demographic characteristics; employment history and present work situation; disabling conditions; job limitations and adjustment; functional limitations and mental health ratings; use of medical care and rehabilitation services; family participation and relationships; and economic resources. Mentally retarded persons age 18 and over who were not institutionalized at the time of the survey are included in these studies. Reports summarizing the data will be available this year.

SURPLUS PROPERTY PROGRAM

The Office of Surplus Property Utilization, Office of Facilities Engineering and Property Management, within the Office of the Assistant Secretary for Administration and Management, carries out the responsibilities of the Department under the Federal Property and Administrative Services Act of 1949, as amended, which makes 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 having no further Federal utilization.

Surplus personal properties generating at Federal installations in the United States, Europe and Southeast Asia, 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 Perperty 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 potentially eligible applicants, either by the State Agencies or the Assistant Regional Directors for Surplus Property located in our ten 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 100 percent public benefit allowance applied against the sales price. Land, or land and buildings together with other improvements, are conveyed by deed which contains restrictions as to use for a period of 30 years. These properties are conveyed with public benefit allowances ranging up 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 which 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, and a directory of the State Agencies for Surplus Property and the ten 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.

Real property has been conveyed for many and varied programs related to the education, training, rehabilitation, and care of the mentally retarded. The State of Missouri passed legislation authorizing the State Department of Education to establish and operate State schools for mentally retarded in any county or in a district comprised of two or more counties. One of the first of these schools was established on a 5 acre portion of the surplus VA O'Reilly General Hospital in Springfield, which we conveyed for this purpose in 1964. This facility is a day school with a current enrollment of 124 chilren, ages 6-20. The State acquired another 18 acre portion of this same facility for operation of the Springfield Regional Diagnostic Clinic, which serves over 1,000 patients in a 16 county area.

The State of Georgia has established a 400-800 bed rehabilitation facility for the mentally ill and retarded on the former VA Domiciliary, Thomasville, and in 1974 acquired another 18 acre portion, as the site for the care of alcoholics, mentally retarded and handicapped. The State has also established a Regional Mental Hospital at the former U. S. Penitentiary Honor Farm near Atlanta, and the Augusta Association for Retarded Children recently acquired three buildings at Fort Gordon, Georgia, for removal to a new site for the care of retarded.

Many other states operate schools or hospitals on surplus land, such as the Sunland Training Center located at former Graham Air Force Station, Florida; the New York State Hospital operating at the former VA Hospital at Tupper Lake; Ohio's Broadview Center for the Mentally Retarded near Columbua; Lufkin State Hospital in Texas; Kansas Neurological Institute at the former VA Winter Hospital, Topeka; the State of Illinois's hospital and school at Dwight, and many others.

Many programs are operated by other than States, such as counties, local school boards, and associations for the retarded. During Fiscal Year 1974, the Eastern Idaho Child Development Center acquired a portion of the Victor Ranger Station for the training of handicapped, including retarded; Lake Charles Association for Retarded Children, Louisiana, received 8 acres and a building at Chennault Air Force Base. In Kentucky, 3.2 acres and 2 bildings at the former Ranger Headquarters in Williamsburg were conveyed to the Whiteley County Board of Education for classrooms and playground for the retarded, and .38 acre was conveyed to Cumberland River Regional Mental Health Center as the site for a school for retarded. Melwood Horticultural Training Center, Maryland, acquired the former Federal Broadcast Information Station at Oxon Hill for training retarded in horticulture and flower arranging; and in Montana, the Opportunity School Foundation acquired 5 acres at the Forest Service site at Fort Missoula for training the retarded.

Through June 30, 1974, 5,410.61 acres of land and 894 buildings have been transferred to institutions for use in programs serving the mentally retarded. These properties originally cost the Government $49,417,416 and had a fair market value of $20,650,285.

Schools for the mentally retarded operated by State and local agencies of government, as well as many nonprofit schools operated by Associations for the Mentally Retarded or Cerebral Palsy, are major users of surplus personal property acquired through the State Agency Distribution Center of their State. During FY 1974, surplus personal properties having an original acquisition cost of

$340,476,359 were donated to eligible public health, educational and civil defense donees in the States. Representatives of schools for the mentally retarded should establish their school's eligibility with their State Agency and make regular visits to their State Agency Distribution Center(s) to inspect available properties and select items needed by their school.

OFFICE OF HUMAN DEVELOPMENT

Office of Child Development

Mental Retardation

In July 1969, the Office of Child Development (OCD) was established in the Office of the Secretary of HEW to serve as a point of coordination for Federal programs for children and their families and to act as a national advocate of services for children. On April 1, 1973, OCD became a part of a new Office of Human Development at HEW which focuses on groups of Americans with special needs.

OCD's concerns extend to all children from conception through early adolescence, with emphasis on the formative five years of life and on children who are "at risk" because they have special problems. There are two bureaus in OCD: The Children's Bureau, which provides a wide range of technical assistance services relating to programs for children and families, and the Bureau of Child Development Services, which operates Head Start and other innovative early childhood programs.

While OCD does not directly operate any programs specifically for the mentally retarded, the agency has an overall advocacy and leadership responsibility for all children, including children with mental retardation. In line with this responsibility, the Office of Child Development may help plan and recommend programs to deal with mental retardation; develop standards and guidelines for such programs; and provide technical assistance to States and public and private agencies in efforts to help mentally retarded children and youth. OCD works cooperatively with the President's Committee on Mental Retardation, the Office for Handicapped Individuals, the Division of Developmental Disabilities, and other HEW agencies.

A. Children's Bureau

Children At Risk

Beginning in FY 1974, the Office of Child Development has funded research and demonstration activities focussed on two groups of children: (1) children with physical and mental handicaps and (2) institutionalized children who are being returned to the community/home setting. For both these groups of children, the overriding issue is ensuring the child's opportunities for a healthy and enduring experience with family or community life.

Specifically, OCD funds grants: (a) to demonstrate effective methods of recruiting adoptive parents for handicapped children through collaborative efforts between national voluntary agencies serving the handicapped, and State or local social service departments; and (b) to assess deinstitutionalization processes utilized by State and local public institutions and the effects of these deinstitutionalization processes on children's welfare for the purpose of developing effective program models in subsequent years.

B. Head Start

Head Start enrollment has always been open to handicapped children, but greater emphasis is now being placed on their needs. For FY 1976 Head Start will assure that 10 percent of the enrollment opportunities in each State are available to handicapped children. This is in accordance with the legislative mandate contained in P.L. 93-644, the Community Service Act of 1974. Prior to FY 1976 Head Start had implemented a policy of making 10 percent of the enrollment opportunities nationwide available to handicapped children. Head Start staff members are now receiving special training in working with handicapped children. The handicapped receive the full range of Head Start services as well as special health and education services provided by appropriate agencies in the community.

In addition, 14 experimental projects demonstrate new ways of serving handicapped children in Head Start. Six of these projects are early childhood projects jointly funded by OCD and the Bureau of Education for the Handicapped in the Office of Education, and eight are operated by Head Start programs. The projects will develop a variety of approaches for integrating handicapped and non-handicapped children in Head Start programs. The integration of handicapped children in Head Start is viewed as a valuable experience for all the children concerned since it will help them learn to understand and respect human differences.

OFFICE OF HUMAN DEVELOPMENT

Rehabilitation Services Administration

MENTAL RETARDATION

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; personal adjustment, prevocational 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; 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 about 12% of the people rehabilitated from all categories of disability by the State-Federal program of vocational rehabilitation. In 1974, about 46,000 mentally retarded persons were rehabilitated, and approximately the same number will be rehabilitated in 1975, although a higher percentage of them is expected to be more severely retarded.

Basic to the vocational rehabilitation effort has been the growing reliance on counselors and other vocational rehabilitation staff who work exclusively 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 is expected to increase.

The specialized vocational rehabilitation staff working with the mentally retarded has been particularly effective in the development of cooperative vocational rehabilitation-special education programs designed to assist the retarded young person make a satisfying transition from school to work. These cooperative 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 separate agreements with individual school districts. Some programs function only to serve the mentally retarded, while 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 comprehensive evaluation of the retarded young person's vocational rehabilitation potential, 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 a rehabilitation facility may be established by State rehabilitation agencies, or by the State agency in cooperation with 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. In all cases, State or private financial resources must be used to match Federal funds.

Other rehabilitation facility improvement activities are: (1) a program of technical assistance consultation to provide workshops and other facilities with special consultation services in such areas as workflow, safety engineering, contract procurement, and vocational evaluation and adjustment; and (2) projects to share in the cost of providing training services for handicapped individuals in public or nonprofit 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 and the provision of occupational tools and equipment necessary for training purposes and job tryouts.

Rehabilitation training in mental retardation has focused on rehabilitation counselor training by supporting field units in which student trainees can concentrate their practicum experience in work with this client population. Such grants also support field instructional faculty. In 1974, six Regional short-term training seminars with a special focus on mental retardation and other developmental disabilities were also supported under the rehabilitation training program. Seminar titles and course sponsors were: Preparation of the Developmentally Disabled for Adult Life - Illinois State Pediatric Institute; Serving the Severely Retarded - Puerto Rico Division of Mental Retardation; Interagency Approach to the Rehabilitation of the Mentally Retarded - Texas Tech University; Service Coordination for the Developmentally Disabled - University of Colorado Medical Center; A Developmental Process for the Developmentally Disabled - University of Wisconsin; Generic Training for Services to the Mentally Retarded - Weber State College.

Rehabilitation Research and Demonstration

A comprehensive overview has been completed for types of training programs given the retarded throughout the United States, and the environmental and personal characteristics that have contributed to their vocational adjustment. Similarly, a project studied the later social and vocational adjustment of 575 retarded individuals discharged from a training center over a 9-year period to determine those variables that facilitated their ability to get along in society. A satellite workshop program has demonstrated that several workshops in inner city areas were able to provide a variety of prevocational and vocational training experiences which they could not have provided separately.

Future projects will be concerned with improved delivery of services to the retarded with the most effective mix of services to deinstitutionalize the mentally retarded, and with the development of techniques designed to place more effectively the developmentally disabled client. Various projects, located in the communities, will demonstrate different ways of involving the parents and other family members in the rehabilitation process of the retarded client.

In the past three years, the Rehabilitation Research and Training Centers have concentrated much of their research activities on the deinstitutionalization of the mentally retarded and on how they can be assisted in adjusting to community living. More recent research projects are addressing the vocational rehabilitation of the mentally retarded, especially the profoundly retarded, and preliminary findings are highly encouraging. At the Oregon University RT Center in Mental Retardation, profoundly retarded individuals are given special training in self-care and in certain skills of which they are found capable. The majority of the subjects are now self-sufficient, and many of them are employed in jobs which pay the minimum wage. Results of these research projects are translated into training material which can be used by VR Agency personnel, either as part of their regular training programs or to meet specific needs.

Rehabilitation Services Administration

The Rehabilitation Services Administration is responsible for a broad range of programs designed to provide habilitation and rehabilitation services for the developmentally disabled including the mentally retarded. These programs cover support for planning, administration, services and the construction of community facilities through formula grants to States as well as support for project grants designed to reduce the resident population in large State institutions for the retarded by making available specialized community services and by increasing the use of generic services. Also included are grants for: Core support of interdisciplinary training programs in university-affiliated facilities for manpower needed for the training, care and treatment of the developmentally disabled; improvement of services in State residential facilities for those retarded who are appropriately placed; training of professional supportive and technical personnel already engaged in occupations involved in the care and rehabilitation of the developmentally disabled; planning and construction of rehabilitation facilities and sheltered workshops; special projects for expansion and innovation of vocational rehabilitation services.

These diverse activities are unified by the common goal of assisting the developmentally disabled, including the mentally retarded to achieve and maintain the maximum personal, social and economic independence of which they are capable. Underlying these activities is the continuing concern for expanding opportunities and resources available to the substantially handicapped among the developmentally disabled.

1. Developmental Disabilities

a. Formula Grants to States

The Title I, Part C of the Developmental Disabilities Services and Facilities Construction Act of 1970 (P.L. 91-517) which amended the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 (P.L. 88-164) authorized formula grants to States for comprehensive planning, administration, services and construction for the developmentally disabled. The 1963 Act limited Federal support to facilities and programs for the mentally retarded. The 1970 Act extends support to include not only mental retardation but also cerebral palsy, epilepsy, and other neurological conditions approved by the Secretary. The Developmental Disabilities Act calls for Federal, State and local governments and voluntary agencies to share responsibilities for establishing and maintaining programs that will enable the developmentally disabled to: (1) enhance their physical, intellectual, and social capabilities to the fullest extent possible; (2) gain emotional maturity commensurate with social and intellectual growth; and (3) attain skills, habits, and attitudes essential to living a personally satisfying life.

Federal support is available for a wide range of diversified services in terms of life-time human needs of the developmentally disabled. The Act provides for the co-mingling of funds under this program with those of other State programs. This facilitates the development of comprehensive services for the developmentally disabled through the combination and integration of the efforts in both specialized and generic services of State agencies representing diverse areas such as health, welfare, education and rehabilitation, without imposing a set pattern of services on any one State.

Comprehensive planning of needed services and facilities providing for more efficient and effective utilization of existing human and fiscal resources at all levels is required. New or innovative programs will be developed to fill gaps in existing services and to expand the reach of existing services among new groups of individuals. Services and resources of all State, regional, and local agencies assisting the developmentally disabled will be integrated.

Responsibility is placed at the State level for developing strategies for the successful implementation of the program. Use of Federal funds must not result in a decrease in the level of effort at State and local levels in providing services to persons with developmental disabilities. To the extent feasible, this program should stimulate an increase in effort.

To receive Federal funds under the program, States must submit State Plans to the Regional Director, Office of Rehabilitation Services for approval. The State Plan must include a description of how other State-Federal programs provide for the developmentally disabled and how the new program will complement and augment, but not duplicate, these programs. At least 9 programs must be taken into account: vocational rehabilitation, public assistance, social services; crippled children's services, education for the handicapped, medical assistance, maternal and child health, comprehensive health planning and mental health.

Because of a correlation between poverty and developmental disabilities, a higher Federal share is provided for areas of urban-rural poverty. These higher rates of support offer new incentives to alleviate existing inequities. In poverty areas Federal support for services is 90 percent for the first 24 months of a project and 80 percent for the next 12 months. For construction projects, the Federal share is up to 66-2/3 percent for nonpoverty areas and up to 90 percent for poverty areas.

In Fiscal Year 1974, $30,875,000 was appropriated for this program, and the same amount has been requested for Fiscal Year 1975. The law permits the setting aside of up to 10 percent for projects of national significance. The percent used in 1974 was approximately 5.2 percent and in FY 75 approximately 9 percent has been set aside for this purpose.

For FY 75, State Planning and Advisory Councils have allocated $21,231,000 (73.7%) for services, $7,386,000 (26.2%) for administration and planning, $243,000 (0.1%) for construction. Only four States (California, Missouri, Alaska and Washington) have budgeted funds for construction purposes.

In FY 1973, the latest year for which data is available, States expended their allotted funds in the following percent for services to individuals:

Services	Percent	Individuals Served
Diagnostic	5.2	31,566
Evaluation	4.6	30,476
Treatment	7.4	48,504
Personal Care	5.2	2,262
Day Care	7.9	14,929
Domiciliary Care	13.4	806
Special Living Arrangements	8.5	3,188
Training	10.2	16,353
Education	5.6	25,554
Sheltered Employment	7.0	3,682
Recreation	4.2	14,663
Counseling	6.1	16,016
Protective and Socio-Legal	2.3	4,085
Information and Referral	5.4	54,968
Follow-Along	4.0	8,588
Transportation	3.0	6,687
	Total services provided	282,327*

*Many clients received multiple services.

Typical types of projects included:

Gasoline Service Station Training Program

This project is designed to provide a realistic opportunity for developmentally disabled persons to meet and serve customers, to make money change, and to work in the demanding atmosphere of serving the public. Work experience includes pumping gas, washing cars, changing oil, lubricating cars, and servicing new and used cars for automobile dealers in the area. Six clients were initially placed in the project. One is currently working as a service station attendant and five are working in other competitive occupations.

Coordinator to Assist Clergy

Funds were awarded to a private non-profit community agency to hire a coordinator to assist local churches and clergy in becoming involved in planning innovative services to the developmentally disabled people and their families.

Hostels for Severely and Profoundly Handicapped

Two developmental hostels for severely and profoundly retarded children with multiple physical handicaps now in State institutions were established. Each hostel will serve 3 children, prepare them in social skills (eating, dressing, toilet training, physical therapy, recreation and education).

Life Enrichment Program for Adults not Eligible for Workshops Placement

In one community within a State, a small segment of the adult cerebral palsied population are so severely handicapped physically that they do not qualify for existing programs. They are living at home generally with aging

parents who find it increasingly difficult to provide a 24 hour a-day care. These individuals are potential residents in State or private residential care facilities within the foreseeable future. The Life Enrichment Program has removed the handicapped persons from the home on a scheduled basis three afternoons a week to an activity center thereby increasing their capability to live within their family environment.

Cooperative Areawide Transportation System

Nine public non-profit agencies have joined together to form the Cooperative Areawide Transportation System for the purpose of providing transportation services and programs to the developmentally disabled in a large metropolitan area. Future plans call for extending this service into an adjoining State. The services include transporting individuals to and from daily routine activities, special necessary services, special functions and occasions, and delivery of goods to sheltered workshops and activity centers.

Coordination with Other Agencies

The State Planning and Advisory Council was able to refer to other agencies four requests which came to it for funds. These projects were rewritten and expanded to provide better services to the developmentally disabled.

Coordinated Protective Service System

One State has developed a network of protective services including case management and personal advocacy. It represents a joint effort of public and private organizations. Originally projected for high priority areas only, it is now being implemented on a Statewide basis.

Special projects of national significance are designed to provide knowledge and information, technical assistance and evaluation which will improve the planning and delivery of services to the developmentally disabled. Ten projects have been approved since Fiscal Year 1973. No new projects have been approved. The approved projects include:

1-5. Child advocacy: The Division of Developmental Disabilities, Rehabilitation Services Administration has joined with the Bureau of Education for the Handicapped and the National Institute of Mental Health in comingling funds to support five child advocacy projects: The National Association for Retarded Children project catalyzes a nationwide volunteer child advocacy program. Peabody College established four general advocates in four rural counties in Tennessee. The Kentucky Commission on Children established State and regional advocacy offices. The National Easter Seal Society for Crippled Children & Youth aims to perfect a model of advocacy for physically handicapped children. And, the United Cerebral Palsy Association is developing three models of advocacy for developmentally disabled children and their families in three areas of the U.S.A.

6. Legal Advocacy: The Division of Developmental Disabilities, Rehabilitation Services Administration has joined with the Bureau of Education for the Handicapped in comingling funds to support a legal advocacy project at Notre Dame University. It includes a reference system for all national and State legislation on developmental disabilities; a reference system for all national, State, and local legal actions pertinent to the developmentally disabled; an electronic retrieval system for all data in the system; a research arm to study questionable issue pertinent to the legal rights of the developmentally disabled; and eleven other aims related to law.

7. Technical Assistance to State Councils for the Developmentally Disabled: At the University of North Carolina a technical assistance and consultation system has developed a strategy and organization to deliver technical assistance to State and territorial councils for the developmentally disabled, assisting them in their tasks, especially in planning and evaluation, but also including program management, information, and data collection and dissemination. A needs assessment survey is conducted prior to the provision of technical assistance in order to determine critical areas for technical assistance.

8. National Information and Individualized Data Base for the Developmentally Disabled: At the Pacific State Hospital (California) in association with UCLA, a pilot for a national information center and individualized data base has been established to develop an individualized tracking system, individual developmental assessment of progress through a continuum of services, evaluation of programs providing services to individuals, groups, and families, and derivation of a benefit-cost analysis on services rendered, including living arrangements. The project will fill the void that exists in terms of information about services and individuals in the national system.

9. National Conference of State Councils for the Developmentally Disabled: The Council for Exceptional Children conducted a national conference of State Councils with the National Advisory Council on Developmental Disabilities. The conference had as its aim an encouragement of a fuller understanding and effective implementation of the Developmental Disabilities Act, provision of up-to-date technical information relative to the functions of planning and evaluation of services for the developmentally disabled, development and extension of communication between the National and State councils, and provision of a forum for discussion of issues related to the Developmental Disabilities Act, and its programs.

10. Deinstitutionalization, including institutional reform and community alternatives for the Developmentally Disabled: Fourteen grants were made to various agencies to demonstrate innovative ways of carrying out this objective, which will have generalizability to other locales. In addition, small grants were made to 47 States to develop long range plans for improving and reducing the population of institutions. These plans are to become part of the basic State Developmental Disabilities Plan.

b. University-Affiliated Facilities for the Developmentally Disabled

Under Title I, Part B of the Developmental Disabilities Services and Construction Act of 1970, the University-Affiliated Facilities for the Developmentally Disabled Program provides for Federal support for interdisciplinary training in institutions of higher learning as well as for the construction of facilities to house these programs. Grants may be made to cover the costs of administering and operating demonstration facilities and training programs for personnel needed to render specialized services to persons with developmental disabilities. In Fiscal Year 1975, $4,250,000 is available for this program through continuing resolution. Grants were made to 33 facilities to partially fund expenses of administration and operation and one percent utilized for evaluation of the program.

Among the professional disciplines trained 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 program so that each discipline involved in the habilitation and rehabilitation of the developmentally disabled may be fully familiar with the contributions of the other disciplines.

c. Project Grants for Rehabilitation of the Developmentally Disabled

The thrust of the Rehabilitation Act of 1974 is to extend vocational rehabilitation services to persons who are more severely disabled, including the developmentally disabled, provided these individuals have a handicap to employment, which handicap can reasonably be expected to be reduced or eliminated by vocational rehabilitation services. There will be need for a wide variety of demonstrations of methods for helping the developmentally disabled who are handicapped in relation to employability to obtain, keep and advance in employment.

Within the eligible developmentally disabled population such innovative services should be brought to bear on such nationally significant problems as changing the existing peonage systems within State mental retardation institutions to short-term work-training positions linked directly to highly supervised work placements in nearby communities and subsequently to competitive employment in outlying areas of the State.

Special projects are to demonstrate means of delivering vocational services to these adult SSI applicants who are found by disability determination screening to be marginally non-feasible for vocational rehabilitation services. Priority is to be given to the basic vocational rehabilitation processes which will have to be adapted to the needs of the more severely handicapped developmentally disabled.

d. Mental Retardation Hospital Improvement Program

The Mental Retardation Hospital Improvement Grant Program is designed to assist State institutions for the mentally retarded to improve their care, treatment, and habilitation services. The program is specifically focused on

the demonstration of improved methods of services and care, as opposed to research exploration or the development of new knowledge.

The ultimate intention of improving institutional services is to increase the number of residents to be either readied for return to the larger community or to become less dependent through improved habilitation approaches.

The projects would continue to emphasize depopulation of overcrowded institutions, assist formerly institutionalized retardates to be more successfully assimilated into the community, continue support of professional and technical personnel in community facilities, develop innovative means to prevent institutionalization, and provide the means to train parents in the habilitation of their developmentally disabled children.

APPENDIX

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

Obligations for Mental Retardation Activities

Fiscal Years 1974-1976
(Thousands of Dollars)

	1974	1975 Revised Budget Estimate	1976 Budget Estimate
OFFICE OF EDUCATION			
Services			
Title I, ESEA, Educationally Deprived Children	$ 52,500	$ 52,500	$ 52,500
Title II, Library resources	1,500	1,500	1,500
Title III, Supplementary centers	5,800	5,800	2,900 1/
Education for the Handicapped Act, Part B	15,000	15,000	15,000
Education for the Handicapped Act, Part C, Section 623	988	1,000	1,000
Education for the Handicapped Act, Part F	3,000	3,000	3,000
Vocational Education Act, Part B	20,000	20,000	2/
Total, Services	$ 98,788	$ 98,800	$ 75,900
Training			
Education for the Handicapped Act, Part D	$ 10,240	$ 10,240	$ 10,240
Education Professions Development Act	---	---	---
Total, Training	$ 10,240	$ 10,240	$ 10,240
Research			
Education for the Handicapped Act, Part E	$ 2,625	$ 3,000	$ 3,000
Total, Research	$ 2,625	$ 3,000	$ 3,000
Other			
Library Services and Construction Act	$ 75	$ 37	$ 27
Total, Other	$ 75	$ 37	$ 27
TOTAL, OFFICE OF EDUCATION	$111,728	$112,077	$ 89,167

1/ These programs are being consolidated in fiscal year 1976 into a consolidated education grants program, which specifies that 50% of total funds must be used for activities funded in the previous year. In fiscal year 1977, total grant consolidation will be achieved.

2/ New legislation will be proposed for the programs involved. No estimates can be included for those activities.

PUBLIC HEALTH SERVICE			
Services			
Health Services			
Maternal and Child Health Services (Section 503, Title V, SS Act)	$ 6,988	$ 6,988	$ 5,031
Crippled Children's Services (Section 504, Title V, SS Act)	6,002	6,002	4,321
Preventive health services			
Disease Control (P.L. 91-695 & 93-151)	7,089	5,812	3,872
Total, Services	$ 20,079	$ 18,802	$ 13,224

	1974	1975 Revised Budget Estimate	1976 Budget Estimate
PUBLIC HEALTH SERVICE (CONTINUED)			
Training			
Health Services			
Training for Health and Related Care of Mothers and Children (Section 511, Title V, SS Act)	$ 14,382	$ 14,382	$ 11,506
Maternal and Child Health Services (Section 503, Title V, SS Act)	2,767	2,767	1,992
Crippled Children's Services (Section 504, Title V, SS Act)	2,998	2,998	2,159
National Institutes of Health			
National Institute of Neurological Diseases and Stroke	1,864	1,195	613
National Institute of Child Health and Human Development	2,109	1,554	1,530
Alcohol, drug abuse, and mental health			
Mental health (Section 303, PHS Act)	125	127	204
Total, Training	$ 24,245	$ 23,023	$ 18,004
Research			
Health services			
Research relating to Maternal and Child Health and Crippled Children's Services (Section 511, Title V, SS Act)	$ 1,600	$ 1,600	$ 1,280
National Institutes of Health			
National Institute of Neurological Diseases and Stroke	5,412	4,246	4,511
National Institute of Child Health and Human Development	19,622 1/	17,310	17,362
Alcohol, drug abuse, and mental health			
Mental Health (Section 301, PHS Act)	626	620	622
Total, Research	$ 27,260	$ 23,776	$ 23,775
Other			
Health resources			
Health Care Facilities (Title VI, PHS Act)	$ 74	---	---
Total, Other	$ 74	---	---
TOTAL, PUBLIC HEALTH SERVICE	$ 71,658	$ 65,601	$ 55,003
SOCIAL SECURITY ADMINISTRATION			
Income Maintenance			
Estimated Benefit Payments from RSI-DI Trust Funds	$298,080	$352,080	$408,240
Trust Fund Obligations Incurred to Adjudicate Claims of Beneficiaries	4,471	5,281	6,124
General Fund Payments for Supplementary Income 2/	154,148	377,808	450,216
General Fund Obligations Incurred to Adjudicate Claims for Supplementary Security Income	9,249	22,668	27,013
Total, Income Maintenance	$465,948	$757,837	$891,593

1/ Includes restoration of 1973 impounded funds.
2/ Includes federal contributions toward State supplementation (hold harmless).

	1974	1975 Revised Budget Estimate	1976 Budget Estimate
SOCIAL SECURITY ADMINISTRATION (CONTINUED)			
Health Insurance			
Estimated Payments from HI Trust Fund	$ 9,760	$ 17,400	$ 21,500
Estimated Payments from SMI Trust Fund	6,180	11,820	15,300
Trust Fund Obligations Incurred to Process Health Insurance and Supplementary Medical Insurance Claims	893	1,636	2,061
Total, Health Insurance	$ 16,833	$ 30,856	$ 38,861
TOTAL, SOCIAL SECURITY ADMINISTRATION	$482,781	$788,693	$930,454
SOCIAL AND REHABILITATION SERVICE			
Services			
Social Services, SS Act	$202,600	$224,900	$247,000
Medical Assistance, Title XIX, SS Act	360,000	415,000	480,000
Total Services	$562,600	$639,900	$727,000
Income Maintenance			
Grants to States for Public Assistance Aid to Permanently & Totally Disabled	$127,248	$ 523 1/	$ 530 1/
Total, Income Maintenance	$127,248	$ 523	$ 530
TOTAL, SOCIAL AND REHABILITATION SERVICE	$689,848	$640,423	$727,530
OFFICE OF THE SECRETARY			
Rehabilitation Services Administration:			
Services			
Rehabilitation Services			
Grants to States, VR Act, Sec. 110	$ 83,850	$ 85,000	$ 89,080
Innovation Grants, VR Act, Sec. 120	---	---	---
Expansion Grants, VR Act, Sec. 120	100	---	---
Facility Improvement Grants, VR Act, Sec. 302(b)(c)	2,530	2,440	2,200
Services for the Developmentally Disabled			
Formula Grants for the Developmentally Disabled (P.L. 91-517, Sec. 131) 1/	21,792	20,607	20,607
Hospital Improvement, PHS Act, Sec. 303	5,997	5,997	6,000
Initial Staffing (P.L. 88-164, Sec. 141)	---	---	---
Project Grants, VR Act, Sec. 304(b)(1)	8,275	12,500	12,500
Total, Services	$122,544	$126,544	$130,387
Research			
Research and Demonstrations, VR Act, Sec. 202(a)	$ 750	$ 650	$ ---
Research and Training Centers, VR Act, Sec. 202(b)	935	935	935
Rehabilitation Activities Overseas (Special Foreign Currency Program)	---	200	425
Total, Research	$ 1,685	$ 1,785	$ 1,360

1/ Guam, Puerto Rico and Virgin Islands only.

	1974	1975 Revised Budget Estimate	1976 Budget Estimate
OFFICE OF THE SECRETARY (CONTINUED)			
Rehabilitation Services Administration (Continued):			
Training			
Services for the Developmentally Disabled VR Act, Sec. 304(b)(1) - Project Grants	$ 4,225	$ ---	$ ---
Hospital Improvement, PHS Act, Sec. 303	23	23	---
Rehabilitation Training, VR Act, Sec. 201 (a)(2) and 203	34	---	---
Total, Training	$ 4,282	$ 23	$ ---
Construction			
Developmental Disabilities Formula Grant 1/	$ 1,380	$ 172	$ 172
Total, Construction	$ 1,380	$ 172	$ 172
Other			
Services to the Developmentally Disabled University-Affiliated Facilities Demonstration Grants (P.L. 91-517, Title II)	$ 4,335	$ 4,250	$ 4,250
Formula Grants for Developmentally Disabled (Planning & Administration, P.L. 91-517, Sec. 131) 1/	5,793	7,091	7,091
Total, Other	$ 10,128	$ 11,341	$ 11,341
Total, Rehabilitation Services Administration	$140,019	$139,865	$143,260

1/ Funds authorized under P.L. 91-517 are obligated for programs in the areas of mental retardation, cerebral palsy, epilepsy and other neurological conditions closely related to mental retardation or requiring treatment similar to that required for mentally retarded persons. The reporting system that provides program data for this authority does not indicate the extent of participation of any one of these conditions. The funds are used for mental retardation as well as other categories that are defined as developmental disabilities. Estimates for mental retardation only are, therefore, not available; the amounts shown in the accompanying table are the total obligations for developmental disabilities. It is assumed that since the emphasis of the program, according to the definition, is on mental retardation, a substantial portion of the funds are expended in the area of the severely handicapped mentally retarded.

Office of Child Development:			
Services			
Head Start 2/	$ ---	$ ---	$ ---
Office for Handicapped Individuals	335	600	600
President's Committee on Mental Retardation	656	656	656
TOTAL, OFFICE OF THE SECRETARY	$141,010	$141,121	$144,516
Total, Grants and Services	$903,829	$989,555	$1,054,547
Total, Income Maintenance	$593,196	$758,360	$892,123
GRAND TOTAL, ALL FUNDS	$1,497,025	$1,747,915	$1,946,670

2/ Dollar estimate of Head Start and Child Welfare amount not available. Mentally retarded children are served in an integrated setting and funds are not specifically budgeted for mentally retarded children.

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

REPORT ON MIGRANTS

A REPORT FOR THE

HOUSE COMMITTEE ON APPROPRIATIONS

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
PROGRAMS FOR MIGRANT AND OTHER SEASONAL FARMWORKERS

The population of migrant and other seasonal farmworkers in the United States faces a wide variety of problems including low wages and seasonal unemployment, limited coverage under labor legislation, lack of job opportunities, job displacement, undereducation and critical health and housing needs.

At present, the Department of Health, Education and Welfare has the responsibility for four programs which are directly targeted to this population. They are as follows:

1. Office of Education

Legislative authority:
Elementary and Secondary Education Act of 1965, as amended; Title I (20 U.S.C. 241b)

Objective:
To provide grants to States for programs and projects to meet the special educational needs of children of migratory agricultural workers and to coordinate with similar programs and projects in other States.

Programs:
Grants to States.

2. Office of Child Development

Legislative authority:
Economic Opportunity Act of 1964, as amended; section 222 (42 U.S.C. 2809)

Objective:
To expand child-care facilities available to children of migrant families and to develop a network of cooperating grantees to serve these children both while migrating and while they are in their home areas.

Programs:
Child-care and Head Start programs in seventeen States.

3. Health Services Administration, Bureau of Community Health Services

Legislative authority:
Public Health Service Act, as amended on September 25, 1962 (42 U.S.C. 242h), commonly referred to as the Migrant Health Act of 1962.

Objective:
To provide grants to public and non-profit institutions and organizations to finance part of the cost of (1) establishing and operating family service clinics and (2) special projects to improve health services and health conditions for domestic agricultural migratory and seasonal workers.

Programs:
Full-time comprehensive health service projects.
Part-time comprehensive health service projects.
Part-time medical service projects.
State-coordinated projects offering direct health services in several counties.
Other health service projects.

4. Office of Human Development, Rehabilitation Services Administration

Legislative authority:
Rehabilitation Act, section 304(c)

Objective:
To provide vocational rehabilitation services to handicapped migratory and other seasonal farmworkers.

Programs:
Eight projects in selected States. Programs are presently in the planning stage.

OFFICE OF EDUCATION

REPORT ON MIGRANTS

(Fiscal Year 1976)

Title I of the Elementary and Secondary Education Act, Public Law 89-10, as amended, provides payment to State educational agencies for assistance in educating migratory children of migratory agricultural workers and migratory fishermen.

Funds are used for programs which are designed to meet the special educational needs of such migratory children, and to coordinate these programs and projects with similar programs and projects in other States.

A migrant student record transfer system is located in Little Rock, Arkansas. Teletype terminals are located in 137 strategic areas serving the 48 continental States. Provisions are now being made to accommodate and provide the record transfer system services to migratory children in Alaska, Hawaii, Puerto Rico, Guam, American Samoa, the Virgin Islands, and the Trust Territory of the Pacific Islands. These migratory children are now eligible for migrant program services as authorized by Public Law 93-380. This transfer system is funded by an equal percentage of each State's allocation set aside by the U.S. Commissioner of Education. The purpose of the system is to provide to school districts enrolling migratory children rapid transmittal of pertinent general, health and academic data for each migratory child.

This system was developed through the cooperative efforts on behalf of the participating States through the work of an interstate committee. The program direction, specifications for the computer, and the manner by which the system was to be operated was the task given and completed through this cooperation.

Because of the mobile nature of the target population, traditional educational practices needed to be adapted to meet this transitory state of migrant children in an educational environment. Since the inception of the program, States have undertaken this challenge and have developed unique approaches to meet these specific conditions. These efforts have resulted in the earn and learn vocational programs in Florida, New Jersey and North Carolina, in which career awareness and salable skills have been introduced such as supermarket cashiering, assembly line techniques and quality control, automotive tune up, and paramedic training, just to mention a few. These activities provide a small monetary compensation to the migrant student which places relevancy in instructional services acknowledging the economic situation in which the migrant finds himself.

The California Mini-Corps Program was designed to utilize current and former migrant children as tutors and program assistants. It has had a two-fold impact: 1) provides assistance to former migrant pupils in order for them to pursue further educational opportunities in junior colleges and colleges, and 2) provides a model for individualizing instruction to further the educational achievement level of underachieving migrant children.

Since the inception of the program much attention has been focused on the language development of migrant children. These language development efforts have taken the form of bilingual and bicultural instructions, the development of oral language skills, and programs for English as a second language. The migrant program has made a reality of the inservice training of teachers as a basic component of all State activities to facilitate the adequate and efficient delivery of services to migrant children. Because of the mobile nature of the children, cooperation between sending and receiving States is required in order to insure a continuum of educational service. As a result of that challenge the States have cooperated in exchanging teachers, mobile educational facilities, cooperative workshops and conferences, and consultant services.

Currently there are three major interstate program thrusts. The States of Minnesota, Wisconsin, Illinois, Indiana, Ohio, and Michigan have formed a consortium of States to cooperatively plan and implement programs in their respective areas. Thirteen western States have assumed a similar responsibility regarding their migrant population. The States on the east coast have already demonstrated their cooperation and concern in interstate efforts by meeting at least annually to share ideas and discuss concerns relating to the east coast migrant stream. In May of 1975, the southeastern States will co-host the 8th Annual National Conference on Migrant Education in Louisiana. This conference is initiated, organized and participated in by all the States providing educational services for migrant children.

An estimated 360,000 migrant children were served under this program in 1974. This figure will rise to approximately 430,000 in 1975 and 500,000 in 1976. These estimates are based on the expanded eligibility provision of Public Law 93-380.

Public Law 89-10 ESEA Title III, Supplementary Educational Centers and Services, enables schools to provide programs presently unavailable to children to raise the quality of educational services already offered, and to stimulate the development and evaluation of experimental elementary and secondary education programs to serve as models. Fifteen percent of program funds is mandated for projects serving handicapped children. Other funds are mandated for projects in guidance, counseling and testing.

Originally, the Commissioner made grants directly to local education agencies. Beginning in fiscal year 1971, 85 percent of Title III funds were administered by State educational agencies, with fifteen percent to be used at the Commissioner's discretion within the State.

A project in Clovis, New Mexico which had been in operation for 3 years was completed at the end of FY 1974.

While the Title III Discretionaly funds are not being used to fund new developmental efforts in Migrant Education, State Facilitators funded with Discretionary money as a part of the National diffusion network are assisting school districts to adopt migrant education programs which have been approved by the OE Dissemination Review Panel.

In 1976 Title III will be included in P.L. 93-380 as a part of Title IV-C, Support and Innovation.

Obligations for Programs for Migrants

	1974 Actual	1975 Estimate	1976 Estimate
Elementary and Secondary Education:			
Educationally Deprived Children (Title I)	$78,331,437	$92,000,000	$117,000,000
Supplementary Services (Title III)	128,000	---	---
Total	78,459,437	92,000,000	117,000,000

Obligations for Programs for Migrants

	1974 Actual	1975 Estimate	1976 Estimate
Occupational, Vocational, and Adult Education			
Adult education-grants to States	$1,200,000	$1,200,000	$1,200,000

The purpose of the Adult Education Act of 1966, as amended, is to establish and expand programs of Adult public education so that adults can continue their education through completion of secondary school and secure job training to enable them to be more employable, productive, and responsible citizens.

Adults sixteen years of age and older (including migrants) with less than a twelfth grade level of education are eligible for participation in this program. However, many State and local education agencies do not keep records of how many migrants participate in local programs or the amount of funds expended on such participation. It is estimated that approximately 18,000 adults participate in the program.

The Vocational education program funds mave many programs assisting children of migrant workers, but there have been no attempts to record them as separate from other children and no accounting for dollars by this category.

Obligation for Programs for Migrants

	1974 Actual	1975 Estimate	1976 Estimate
Library Resources:			
Public Library services (LSCA, Title I)	$200,372	$ 80,000	$60,000
School library resources (ESEA, Title II)	200,000	190,000	1/
	400,372	270,000	60,000

Under the provisions of Title I of the Library Services and Construction Act, a State formula grant program, funds are made available for the development of programs designed to provide library services for the disadvantaged in rural areas and to extend library service to geographical areas and groups of persons without such service.

In 1974, at a cost of $200,372, five projects in the five States of Florida, California, Kansas, New Mexico, and Iowa focused on the library needs of migrant workers and their families.

Library services provided specifically for migrants are bookmobile services and library resource center services. Projects in California and Kansas illustrate these services.

California - "Biblioteca Ambulante", a mobile unit, operates in four counties of central California. This continuing project is providing library service primarily to migrant workers, labor camps, and disadvantaged areas--isolated rural areas of Fresno, Madera, Kings, and Tulare counties and the city areas of Hanford and Tulare. This bookmobile is designed for audio visual materials as well as books, and Spanish-speaking personnel are serving the Spanish-American population.

With the continuation of Biblioteca Ambulante services it is hoped that the ultimate goal of the project can be attained: to direct the rural disadvantaged Mexican-Americans to utilize public library facilities and to direct the public library to consider and fill the needs of Mexican-Americans who constitute a major part of the area's growing population. It is a demonstration project for migrants who have a right-to-read.

Kansas - Services in Kansas provide special "Reach-out" Reading Centers for the migrants moving through the Southwest Kansas Library System. Of the target group of approximately 2,300, at least 500 were identified as users in first year of Teaching Collections of books are made available to migrant groups wherever they are camped and when possible they are encouraged to make use of special services at established library branches and mobile units.

Title II of the Elementary and Secondary Education Act grants funds to the States for the provision of school library resources, textbooks, and other instructional materials for the use of children and teachers in public

and private elementary and secondary schools. Certain target groups of children who have greater need for materials have more made available to them under the States' relative need formulas. One such group is the children of migrant workers. Examples of ESEA Title II projects benefitting these children are:

Sunny Ridge School, School District No. 131, Nampa, Idaho - Five learning centers for study, research, and recreation are provided for primary school pupils (largely children of migrant farm workers). Emphasis is placed upon improving listening, speaking, writing, and reading skills through extensive use of printed and audiovisual materials and audiovisual equipment. Audiotapes are used to provide new listening and learning experiences. The enrichment programs include use of films, filmstrips, books, and magazines on subjects of cultural interest as well as subjects that aid in the achievement of instructional objectives. ESEA Title II funds supplied the materials.

Pershing County School District, Lovelock, Nevada - A project to enable pupils to reach their maximum potential in reading through the use of materials geared to individual needs serves all pupils in the four schools of the county. These schools had particular need for bilingual materials for children of migrant parents, all Spanish-surnamed. To guide their pupils in the use of these materials, teachers and librarians are becoming more sensitive to the cultural patterns of their pupils, recognizing that these patterns influence their values, interests, motivations, and behavior. Another special need of the schools was for very easy reading material for pupils in the first four grades. All four schools had a need for media to support the general elementary and secondary school curriculum. Heavy emphasis is placed on reading skills in all grades. Pupils in the first three grades spend a considerable share of the day in learning to read. In the middle grades, teaching is directed toward reading for meaning and development of study skills. In the secondary school, teachers use many methods of instruction that require pupils to read, interpret, and analyze, and to locate, select, organize and interpret information. The materials were acquired under ESEA Title II.

Obligations for Programs for Migrants

	1974 Actual	1975 Estimate	1976 Estimate
Elementary and Secondary Education:			
Educationally deprived children (Title I)	$78,331,437	$92,000,000	$117,000,000
Supplementary services	128,000	---	---
Subtotal	78,459,437	92,000,000	117,000,000
Occupational, Vocational, and Adult Education:			
Adult education-grants to States	1,200,000	1,200,000	1,200,000
Library Resources:			
Public library services (LSCA, Title I)	200,372	80,000	60,000
School library resources (ESEA, Title II)	200,000	190,000	1/
Subtotal	400,372	270,000	60,000
Total	80,059,809	93,470,000	118,260,000

1/ Federal support for this program is included in the consolidated education grant program.

OFFICE OF HUMAN DEVELOPMENT
Office of Child Development
Migrant Head Start

The Indian and Migrant Program Division (IMPD) in the Office of Child Development (OCD) funds grantees to provide comprehensive developmental services to migrant preschool children and their families.

Because of the unique needs of migrant farmworking families, programs had to be designed to provide the family with access to these resources without creating economic or other hardships. Resources alone, without an adequate system of delivery, will not solve the problems of migrant families with preschool children.

IMPD has developed and worked with several different program models during the past few years. Some of these models have proven to be less successful than others. IMPD's findings have shown that if any given area or region, a combination of program models is necessary to meet the existing needs.

All of the models used a basic program design which incorporates Head Start standards and quality child care services. This design calls for some structural modifications to the traditional Head Start program including: (1) extending the hours of operation to coincide with the parents' working hours; (2) allowing all preschool children to participate, including infants, and (3) utilizing bilingual and bicultural staff where needed. These modifications are necessary in order to provide the type of full service program which is tailored to the life style of migrant families.

Basically, there are two catagories of program models, the Local Programs and the National Programs. Local Programs are Head Start programs which are funded to serve local communities, and which may also serve migrant children. There are two types of local program models which serve migrants; the traditional model and the catered model. The traditional model is one which is designed for all the children in the community with no special adaption for migrant children.

The catered model is one which is designed exclusively or primarily for migrant children. These programs incorporate the three structural modifications and adopt other program features to meet the needs of the target population. A major limitation is the inability to provide a continuity of program services after the family leaves a particular community. The length of attendance is determined by duration of employment.

There are two National Program models; the Prime Grantee model and the Network model.

The Prime Grantee model approached the need to extend the period of services by funding programs in user areas which had longer field work seasons and could operate in one location for four or five months. Families remaining in the area for the entire work season had access to a full service program and the children received educational benefits from having been enrolled for a sufficiently long period. However, this program model did encounter some problems. Most Head Start programs operating in user areas have difficulty in recruiting qualified personnel for two reasons. First, the programs' operating time usually overlaps with the school term and most teachers will accept only summer of full year contracts. Second, there is a lack of qualified personnel who can teach bilingually. Ideally, the staff would share a common primary language with the children but it is almost as difficult to find qualitied staff with a secondary langauge knowledge.

The prime grantee model also attempted to deal with the problem of program continuity. A referral system was devised to refer participants to Head Start programs operating in their home base areas. The child's medical and educational records would also be transferred. The home base programs, however, are under no obligation to accept referrals and frequently the programs are filled by the time the child returns to the area.

The network model differs from the others in that it operates programs in both the home base areas and user states. The program operations follow the migrant streams during the seasons when field work is available and are located in established centers where large concentrations of migrants are found. As the families move from one area to the next the children can be enrolled at the next site. As the target population increases or decreases in a given area, staff members can be regrouped to accommodate the change. This model facilitates recruiting of both staff and participants, provides year-round programs, insures parent participation especially in the off season at the home base site and allows for adequate follow-up. To obtain the maximum benefit from continuing attendance at different sites, it is desireable to have the centers as similar as possible. This is achieved only with a central administration. Additional advantages of this model include year-round training and career development plans as well as an increase in program quality because of staff continuity from year to year. The network model has generally proven to be the most effective delivery system. It should be stated again that in reality a combination of program models will most effectively meet the needs of migrant farmworker families.

IMPD will continue to refine these models and to develop other innovative approaches to guarantee that delivery systems of quality services are provided to the target population. In addition, IMPD recognizes the growing need for an increased effort in program development on behalf of migrants who are attempting to settle out and for seasonal farmworker families.

OFFICE OF CHILD DEVELOPMENT
Migrant Head Start

Obligations for Migrant Head Start Programs:

	Actual 1973	Actual 1974	Est. 1975	Est. 1976
National Program Models.....	$ 3,420,000	$ 4,500,000	$4,500,000	$4,800,000

PUBLIC HEALTH SERVICE

Health Services Administration
Bureau of Community Health Services

Migrant Health

Migrant health supports projects to provide health care services to migrant agricultural laborers and seasonal farmworkers and their families in order to improve and maintain the level of their health relative to that of the general population. Services provided range from a full grouping of diagnostic, therapeutic, and follow-up medical services with provisions for dental care, health counseling, preventive and outreach services to a more limited focus on specific diseases.

During the current fiscal period (1975) the Migrant Health Program, administered by the Bureau of Community Health Services, HSA, DHEW, supports 105 migrant health projects.

At the present time, these projects provide the main source of health care services for the nation's 3,000,000 migrant and seasonal agricultural farmworkers and their families. By June 30, 1975, these projects will have provided services to 390,000 patients.

A special demonstration program, designed to provide hospital care effectively and economically for a selected migrant population and to gather and evaluate data on hospital utilization and cost of hospital services, was initiated during fiscal year 1974 at a level of $3 million. The Bureau of Health Insurance, SSA, serves as the fiscal intermediary for reimbursing hospitals for care provided to eligible migrants in this demonstration. Twelve migrant health projects have initiated programs with 17 hospitals to provide access to inpatient care for approximately 80,000 migrants at a fixed daily rate.

OFFICE OF HUMAN DEVELOPMENT

Rehabilitation Services Administration

MIGRANTS

The estimated migratory population in the United States is 1,000,000. From the few efforts conducted to date and from data obtained from other programs with experience in migratory labor problems, it is estimated that at least 40,000 persons would be eligible and feasible for vocational rehabilitation services. Discussions with representatives of other Federal programs indicate an eagerness to cooperate in this program. It is expected that rehabilitation components would be added to a number of the more worthy on-going programs as well as creating newly coordinated efforts.

In 1974 funds were appropriated to the extent of $735,000, and the Rehabilitation Services Administration funded eight projects for handicapped migratory agricultural workers and seasonal farm workers under provisions of Section 304(c) of the Rehabilitation Act. This is the first time that appropriations have been made available for vocational rehabilitation of handicapped migrants. The eight projects are located in the following States: California, Florida, Idaho, New Jersey, New York, Oregon, Texas and Wisconsin. Six Regional Offices are involved in the administration of these projects.

In accordance with Section 304(c), cooperation has been obtained from the Office of Education, the Public Health Service, and the Department of Labor, all of which sponsor projects for migratory workers.

Data provided by other programs substantiate proportionately greater health problems and related disabling conditions, and the necessity for concentrated services, including outreach efforts to familiarize migrants about services and to encourage them to modify their migratory patterns in order to be served. Emphasis which can be most effectively focused through this special program is necessary to deliver services, in cooperation with other programs, to migrants who present such unique and extensive problems.

A meeting is planned for April 1975, in Washington, to provide a forum for the exchange of information on rehabilitation services for handicapped migratory workers. Participating will be RSA staff, Project Directors, representatives from cooperating Departments and agencies, and consumer groups.

RSA can make a significant contribution toward the solution of the complex problems of the migrants, particularly as they are related to the preparation for and return of migrant workers to more stabilized employment. The need for extending and improving the delivery of social and rehabilitation services to greater numbers of these people is becoming more urgent in light of USDA projections that there will be a reduction of 55% of the migratory worker force by 1976 due to mechanization.

OFFICE OF HUMAN DEVELOPMENT

Rehabilitation Services Administration

MIGRANTS

Fiscal Year	1974	1975 Estimate	1976 Estimate
Basic State Grants	$ 715,000	$ 748,000	$ 748,000
Service Projects	735,000	736,000	736,000
Total, RSA	$1,450,000	$1,484,000	$1,484,000

State Rehabilitation Agencies: Rehabilitated Migratory Agricultural Workers and Seasonal Farmworkers - Fiscal Years 1972 - 1976

Fiscal Year	All Rehabilitants	Migratory Workers and Seasonal Farmworkers
1972	362,138	181
1973	360,726	265
1974	361,138	400 1/
1975	363,000 1/	600 1/
1976	332,000 1/	900 1/

1/ Estimated

MULTIPLE SCLEROSIS

Multiple sclerosis is one of the most common chronic diseases affecting the human brain and spinal cord. It is characterized by a loss of the fatty sheaths of myelin that surrounds the nerve fiber and derives its name from the plaques or patches of scarred (sclerosed) nervous fibers that dot the central nervous system (CNS). It is estimated that between 100,000 and 250,000 Americans suffer from multiple sclerosis and perhaps an additional 250,000 may be affected by other demyelinating disorders.

The Department's research activities into the causes and better methods of prevention and treatment of multiple sclerosis are centered in the National Institute of Neurological Diseases and Stroke of the National Institutes of Health, and in the Rehabilitation Services Administration of the Office of Human Development for the rehabilitation of multiple sclerosis patients.

Obligations for Programs in Multiple Sclerosis and Related Disorders

	1972	1973	1974	1975 estimate	1976 estimate
National Institutes of Health:					
National Institute of Neurological Diseases and Stroke	$3,611,000	$4,212,000	$4,770,000	$5,500,000	$5,903,000
Office of Human Development:					
Rehabilitation Services Administration:					
Basic State Grants	1,120,000	589,000	1,300,000	2,040,000	2,720,000
Total	4,731,000	4,801,000	6,070,000	7,540,000	8,623,000

2

NATIONAL INSTITUTES OF HEALTH

National Institute of Neurological Diseases and Stroke

Multiple sclerosis--elusive, baffling, and devastating--is known as the great crippler of young adults. That is because this chronic disease of the human brain and nervous system usually strikes its victims between the ages of 20 and 40, ordinarily the most productive years.

A majority of those afflicted may expect to live up to 75 percent of their normal lifespan. But often patients spend those years either totally incapacitated or dependent on their families to help with the most simple, everyday tasks, placing enormous psychological and economic burdens on all involved.

"Now the time has come for a coordinated attack on multiple sclerosis, not only because of the personal devastation multiple sclerosis causes and its social and economic cost, but because there is good reason to believe that if intensified research is undertaken now it will yield, in the foreseeable future, significant advances in its control and eventually practical means to prevent or arrest its further progress."

So concluded the National Advisory Commission on Multiple Sclerosis in its report to the Secretary of HEW, the President and the Congress, after a year-long study of current research and available treatment. The Commission which was appointed by the Secretary of HEW, in accordance with an act of Congress, presented its report in February 1974.

The cause of multiple sclerosis is as yet unknown, its identity shrouded in a myriad of mysteries. Its name denotes its characteristics which were described almost a century ago by the great French neurologist Charcot: loss of the myelin (fatty) sheath around nerve fibers in the brain and spinal cord at scattered "multiple" sites and the later development of hard patches or plaques of "sclerosis" at these sites.

This demyelination, as it is called, is not unique to multiple sclerosis. In fact, there are an estimated 100,000 who suffer from other demyelinating diseases. What is unique to multiple sclerosis is the course of the disease. The multiple symptoms of multiple sclerosis are intermittent, with alternating periods of remissions (improvement), and exacerbations (recurrence and usually worsening of symptoms).

Symptoms usually begin insidiously, involving minor visual disturbances, transient weakness, slight stiffness or unusual fatigability of a limb. Some patients will experience only a few episodes, and will not be bothered again. However, in the majority of patients, the symptoms will eventually become progressively more severe, involving tremor of limbs during movement, severe muscle weakness, and visual disturbances, such as partial blindness in one eye or double vision.

Multiple sclerosis is rarely regarded as the direct cause of death. However, there are often accompanying problems, primarily impaired function or infection of the lungs and bladder, which can be fatal.

The Multiple Sclerosis Commission

The Multiple Sclerosis Commission, composed of five scientist-physicians and four laymen, assisted by 53 specialists from many relevant research areas, presented a number of recommendations which the Institute has been implementing. As suggested by the Commission, an Institute staff scientist has been designated as the focal point for multiple sclerosis. The Commission recommended a total

of five Clinical Research Centers. Two had been funded--one at UCLA and another combined center at the University of Pennsylvania and the Wistar Institute. This past year another one was funded at Emory University in Atlanta.

The Commission also recommended various epidemiological studies of the disease. Two contracts have now been negotiated. One of these relates to the Shetland-Orkney Islands where there is a high incidence of multiple sclerosis. The other is a nation wide survey of the prevalence and cost of multiple sclerosis in this country.

The Commission recommended that the Institute underwrite large immunological and virological research efforts. The Institute has had a strong virological program which it is expanding. Recently, two contracts for study of multiple sclerosis tissues for viruses, biochemical changes, and immunological reactions have been awarded. A new laboratory of neuro-immunology will be operative in the Spring of 1975. Training and fellowship programs in neuro-immunology and neuro-virology also have been inaugurated.

Some of the recommendations, such as developing specific diagnostic tests, establishing mechanisms for providing fresh tissue samples, and promoting various approaches to therapy will take time to implement.

Research Approaches on the Possible Causes of Multiple Sclerosis

Currently, the most encouraging leads to finding the cause or causes of multiple sclerosis appear to be in the fields of virology, immunology, and epidemiology. Fortunately, these three are complementary, and studies in all three fields are under way in intramural research laboratories, through grants and contracts, and at the three Institute-supported clinical research centers.

NINDS scientists discovered some years ago the existence of slow, latent viruses which lie dormant in the body for months or years before some triggering mechanism causes the onset of a nervous system disease. It is possible, therefore, that such a slow virus could infect an infant or young child, and not cause multiple sclerosis symptoms until mid-life.

The Institute is conducting and funding a number of studies on a possible viral cause. For instance, at the Wistar Institute, scientists are pursuing studies on a particular virus, paramyxovirus, which had been isolated at autopsy from two multiple sclerosis patients.

In addition, the NINDS is studying two basic approaches to determining whether a virus may be the cause. In one approach, scientists at the University of Wisconsin are applying a new technique originally developed for use in cancer research. They are purifying brain tissue from multiple sclerosis patients, and placing this purified tissue on a special absorption column containing antibodies (which normally occur in the body to fend off invading viruses). If a virus is present in the multiple sclerosis brain tissues, these antibodies will hold the virus to the column, much like a selective glue. The isolated virus can then be washed off the column, collected and observed with electron microscopy to substantiate its presence.

Another approach is being conducted by scientists at the Scripps Clinic and Research Foundation in California. From known viruses these scientists are taking deoxyribonucleic acid (DNA), a compound found in all living cells, previously labeled with a radioactive tracer material and mixing it with DNA isolated from autopsy specimens of multiple sclerosis brain tissue. The aim is to see if the DNA from known viruses binds with the DNA from multiple sclerosis brain tissue cells. If one or more of the same viruses is present in the brain tissue, their DNA will hybridize or join with the newly introduced viral DNA, and hence will indicate which and how much virus is present in the brain tissue specimen.

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Immunology, a second promising area of research, is a study of the body's defense system against invading disease. Immunological research may have a double task, for it may not only lead to finding the cause of multiple sclerosis, it may also offer help in treatment. This year the Institute created a new laboratory of neuro-immunology which will greatly expand intramural immunological studies.

There is suggestive evidence that the principal cell change seen in multiple sclerosis--destruction of parts of the insulating (myelin) sheath around nerve fibers--may result from what is known as an autoimmune process. This means the body becomes allergic to itself, and its defense systems attack the body's own cells. Several findings point to the involvement of an impaired or misdirected immune response. One is that lymphocytes (a type of white blood cell that both attacks invading microorganisms and produces antibodies) are frequently present at the edge of multiple sclerosis plaques. A second finding is that an antibody fraction, called immunoglobulin G, is increased in the spinal fluid of multiple sclerosis patients.

Interest in the possibility that multiple sclerosis is an autoimmune response comes also from an analogy with the animal disease, experimental allergic encephalomyelitis (EAE). EAE, used for many years to study the role of the immune system in multiple sclerosis, is produced in guinea pigs by injection of an antigen. The applicability of EAE to multiple sclerosis is controversial, however, because although the two diseases have many similarities (primarily demyelination), EAE has a nonprogressive course and does not have multiple sclerosis' characteristic relapses and remissions. Further research may establish whether EAE is indeed a promising lead to understanding multiple sclerosis.

The Institute is supporting a study which should help indicate whether there is an impairment in the immune system of multiple sclerosis patients. In addition, scientists at Rockefeller University are studying a substance known as transfer factor which is present in normal white blood cells. In these normal cells, transfer factor is known to fight viruses which have penetrated the body's first line of defense, the antibodies, (which prevent a virus from entering a cell). Once the virus has penetrated the cell, transfer factor will usually permit the white cells (lymphocytes) to attack the virus infected cell and clear it out. The Rockefeller scientists are determining whether the transfer factor is working in multiple sclerosis patients by giving extracts of white blood cells containing transfer factor of normal persons to multiple sclerosis patients. If these patients improve, scientists may find that the multiple sclerosis patient's transfer factor has been at fault.

A third area of study, epidemiology, is also lending support to the slow virus theory. Studies have shown that if people move from an area of high risk for multiple sclerosis to one of low risk before they reach the age of 15, their risk of developing multiple sclerosis becomes similar to that at their new residence. If they move after age 15, the high risk factor from their old environment stays with them. This may indicate that factors influencing multiple sclerosis are introduced before the age of 15. Migrant workers are being studied in the U.S., Netherlands, France, Great Britain, and Israel to determine which common factors are present or absent in the migrant workers' initial homeland. Epidemiologic studies have also shown that members of higher socioeconomic groups have a higher incidence of multiple sclerosis. This may indicate that people in lower socioeconomic areas who have been exposed to more types of infectious agents may develop immunity to these agents and remain unaffected.

One epidemiological study funded by the Institute involves determining what factors may exist in an area of the world that has an abnormally high incidence of multiple sclerosis, the Shetland and Orkney Islands. Scientists from the Massachusetts General Hospital are investigating enviromental, genetic, and infectious factors in this population, in which 250 per 100,000 persons have multiple sclerosis. It is hoped that the study will help answer such questions as who gets multiple sclerosis, and how?

Research on the Diagnosis of Multiple Sclerosis

Although estimated figures on the prevalence of multiple sclerosis are available, obtaining exact numbers has been extremely difficult because no detailed study has been undertaken to identify the population afflicted, and the degree of incapacitation. The Institute last year let a contract to determine the number of victims and their degree of incapacitation, and also the cost of multiple sclerosis, to the Nation and to individual families, in terms of lost wages.

Difficulty in diagnosing multiple sclerosis in its early stages continues to be a large problem. Certain test results, notably the finding of atypical and increased levels of gamma globulin in the cerebrospinal fluid (CSF) indicate a high probability of multiple sclerosis. No test by itself is conclusive, however, and even a battery of laboratory tests will not give an incontrovertible finding. Physicians are therefore hesitant in informing patients they have a condition as devastating as multiple sclerosis when it may instead be a less serious, transitory disorder. Even when the diagnosis is quite certain, many doctors are reluctant to tell patients what their prospects are, since the disease has such an unpredictable course. Scientists accordingly continue to search for diagnostic determinations that are more certain at an early stage.

It is also important to determine the stage of a patient's disease process at any given time. A patient may appear symptom-free, while in fact the disease process is advancing unabated. In addition, it is important to know what changes are occurring in the body during different stages of the disease, so that the effectiveness of therapy can be gauged. Since the course of multiple sclerosis is so unpredictable, it is difficut to assess whether improvement results from treatment or whether a remission period may be occurring. Information on patients' cellular and chemical changes is being obtained from blood and CSF samples at the three Institute-supported clinical research centers. The samples may provide valuable information on the disease process when correlated with reports by patients on the stage of their symptoms.

NINDS scientists recently developed new techniques to study central nervous system (CNS) demyelination in a new living model system, the optic nerves of Xenopus tadpoles. These tadpoles are transparent, permitting direct observation of their optic nerves. The investigators also have developed a procedure for quickly surveying many CNS myelin sheaths, so that demyelinating lesions can be identified and counted without the delays encountered with standard procedures. The scientists are now using this new model system to test the demyelinating activity of cerebrospinal fluid and serum from multiple sclerosis patients.

It is also important to examine affected tissues of multiple sclerosis patients. The National Multiple Sclerosis Society has supported two centers for the collection, storage and distribution of preserved multiple sclerosis tissue. Studies of these tissues combined with studies of new, fresh tissues, may provide new information on the course of the disease.

Another aid is the newly developed brain scanner manufactured by an English firm, EMI Limited. This combines computer and X-ray techniques to distinguish extremely small differences in the densities of tissues deep in the brain. It may be possible through this technique to reveal areas of demyelination and their extent and progression. These and similar scanners are available at a number of medical centers. The Institute, along with the National Cancer Institute and the Clinical Center, is purchasing one for use at NIH.

Research on Treatment for Multiple Sclerosis

Currently, there is no cure for multiple sclerosis. The most promising lines of investigation involve the immune process. At present possible alternatives in immunotherapy are general suppression of the immune mechanism with

drugs, administration of specific antigens, a process comparable to desensitization in allergic disorders and stimulation of the immune process.

One possibility is the use of transfer factor. If multiple sclerosis is caused by a deficiency of transfer factor in white cells, it may be possible to infuse normal cells with intact transfer factor or an extract of white blood cells which contain transfer factor.

While most research has centered on a deficient immune response, one group of scientists reported recently that multiple sclerosis may result from too much cellular immunity. They are using a substance known as antilymphocyte globulin, which decreases the number of white cells and therefore the number of antibodies. The group, working at three centers in Germany, reported that of 20 patients treated, 11 have significantly improved over a one-to-five-year period. More research is needed to investigate this possibility.

In addition to looking for a curative treatment, research is also centering on treating the symptoms. The National Advisory Commission on Multiple Sclerosis wrote, "Disproportionate emphasis on the search for the basic causes of multiple sclerosis may unwittingly retard the discovery of ways to control, cure or prevent the disease." Symptomatic treatment includes using antispasmodic drugs along with physical therapy to preserve the remaining strength and mobility of the muscles. One new approach is a type of muscle stimulation being tested at Case Western Reserve University in Ohio. Scientists in the Institute's neural prosthesis program to aid spinal cord patients are generating movement in limbs using shoulder muscles to activate a muscle stimulator. When this system is further developed, it may be adapted to help patients with other nerve or muscle disorders, including multiple sclerosis.

Loss of bladder control and the subsequent serious risk of infection is another problem shared by patients with multiple sclerosis and those with spinal cord injury. Here again, a device being tested at Duke University as part of the Institute's neural prosthesis program may also be helpful to multiple sclerosis patients. The device, an electrode system implanted in the patient's spinal cord, activates bladder action. There are still some problems which need to be corrected before the device can be used in the general population.

Another therapy showing promise is use of adrenocorticotrophic hormone (ACTH), hormones of the cortisone group, antilymphocyte serum and two classes of anti-cancer drugs designed to block the metabolism of abnormal cells or selectively destroy such cells. It now appears that ACTH may reduce the severity and perhaps shorten the duration of an acute multiple sclerosis episode for some patients, but there is no evidence that it will postpone relapses or alter the basic course of the disease. Researchers feel, however, that modified forms of these and other drugs may penetrate the blood-brain barrier in sufficient quantity to exert a direct effect without causing intolerable systemic toxicity. Scientists feel that antiviral agents may also be modified to be successful against multiple sclerosis. In addition, they are working to develop compounds that have a demonstrable effect on the immune responses within the CNS.

Research is continuing to explore these several approaches to developing effective treatment both of the symptoms and of the cause of multiple sclerosis. And as more clues are pieced together, it is hoped this collage will evolve into a clear, distinct picture, offering tangible help to those afflicted, and insuring others that this disease will no longer threaten the quality of life.

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OFFICE OF HUMAN DEVELOPMENT

Rehabilitation Services Administration

Because of the nature of the disease, sometimes rapidly progressive and sometimes relatively quiescent for a period of years, multiple sclerosis has been a challenging problem for workers in the field of vocational rehabilitation. Estimating ultimate employment potential is extremely difficult, and the State-Federal program of vocational rehabilitation has had limited success in serving this disability group.

The Rehabilitation Services Administration entered into a Cooperative Agreement with the National Multiple Sclerosis Society in October 1968 for the purpose of expanding and intensifying services for the victims of multiple sclerosis. It was expected that increased coordination between State rehabilitation agencies and local chapters of the Multiple Sclerosis Society would result from this Cooperative Agreement, with the concomitant development of case finding, improvement of service techniques, and expansion of vocational opportunities for the multiple sclerotic. During 1970, representatives of the State-Federal program of vocational rehabilitation were featured speakers and active consultants at the four regional conferences of the National Multiple Sclerosis Society held in New York, Chicago, San Francisco, and New Orleans.

The Rehabilitation Services Administration has also issued a special Medical Bulletin on Multiple Sclerosis to provide the State rehabilitation agencies with current information on this disease, and to stimulate these agencies to increased efforts in rehabilitation of the multiple sclerotic, with greater use of the special program of evaluation services for a period of up to eighteen months as authorized by the Rehabilitation Act being recommended as a helpful resource. The Medical Bulletin cites a study of some 1,300 people with multiple sclerosis which shows that: 70% were able to work within the first 5 years after onset: 50% within 10 years; and that 35% were still gainfully employed between 15 and 20 years after onset.

With further advances in drug therapy, neurosurgical procedures, and rehabilitation techniques, the rehabilitation potential of those suffering with multiple sclerosis should be greater than at present. Since the larger proportion of persons with multiple sclerosis are women in the 20 to 40 age group, one objective should be to accept increasing numbers for services with the vocational goal of homemaker.

The Research and Training Centers supported by the Rehabilitation Services Administration are conducting research on ways through which the handicapping effect of multiple sclerosis can be better understood so that it can be counteracted or minimized. Four medically-oriented Research and Training Centers are conducting studies on the electrophysiological mechanisms in neuromuscular diseases such as multiple sclerosis, on quantitative and qualitative evaluation in diseases of the central nervous system, and on the histochemistry of human muscle spindles.

Number of Rehabilitations with Multiple Sclerosis

Fiscal Year Ending June 30	Persons Rehabilitated	
	Total	Multiple Sclerosis
1973	360,726	500
1974	361,138	400 1/
1975	363,000	700 1/
1976 1/	332,000	1,000 1/

1/Estimate

MUSCULAR DYSTROPHY AND THE NEUROMUSCULAR DISORDERS

The neuromuscular disorders, characterized generally by weakness, wasting, and fatigue of the muscles, generally claim children and young adults as their victims. Some of the neuromuscular diseases cause rapid death and some cause chronic paralysis and invalidism. The two most common disorders in this group, the muscular dystrophies and myasthenia gravis, afflict some 200,000 and 30,000 patients respectively. When other less prevalent neuromuscular disorders are included, estimates of the number of patients with these conditions range from 250,000 to as many as one million.

The Department's research activities in muscular dystrophy and other neuromuscular disorders are centered in the National Institute of Neurological Diseases and Stroke of the National Institutes of Health; its rehabilitation activities are the responsibility of the Rehabilitation Services Administration of the Office of Human Development.

Obligations for Programs in Muscular Dystrophy and Other Neuromuscular Disorders

	1972	1973	1974	1975 estimate	1976 estimate
National Institutes of Health:					
National Institute of Neurological Diseases and Stroke.....	$6,355,000	$5,841,000	$6,722,000	$6,314,000	$6,937,000
Office of Human Development:					
Rehabilitation Services Administration:					
Basic State Grants.....	560,000	589,000	1,300,000	2,040,000	2,720,000
Total.....	6,915,000	6,430,000	8,022,000	8,354,000	9,657,000

NATIONAL INSTITUTES OF HEALTH

National Institute of Neurological Diseases and Stroke

At the National Institutes of Health in Bethesda, Maryland, clinical studies on muscular dystrophy, myasthenia gravis, and other neuromuscular disorders are centered in the National Institute of Neurological Diseases and Stroke's (NINDS) intramural Medical Neurology Branch. Multidisciplinary research is aimed at chosen target disorders, evolving basic research techniques and applying them to clinical neurological problems.

The NINDS also supports some 102 research grant projects related directly to neuromuscular disease in hospitals, medical schools, and universities. The Institute also is continuing its support of a PL-480 collaborative research program in neuromuscular disease with the Warsaw Medical Academy, Poland.

The Institute works closely with the Muscular Dystrophy Association, Inc., and the Myasthenia Gravis Foundation. These two voluntary health agencies also support research in related neuromuscular disorders.

MUSCULAR DYSTROPHY

The Problem

The muscular dystrophies are a group of chronic, inherited disorders characterized by progressive weakening and wasting of the skeletal or voluntary muscles. Most types of muscular dystrophy are inherited, but any may occur spontaneously in a family as the result of a mutation or a new genetic change.

As the disease progresses, a patient may become confined to a wheelchair or have difficulty performing the ordinary activities of living. A common cause of death in these patients is respiratory failure which results from infection. Heart failure also is found in some patients.

Of the three principal types of muscular dystrophy, Duchenne muscular dystrophy is probably the most common. It affects male children almost exclusively and appears when they are between ages 2 to 6. Since it is a sex-linked, recessively inherited disorder, a woman who is a carrier of the trait has one chance in two that each male child born to her will be affected, and one in two that each female child will be a carrier like herself.

The first symptoms in Duchenne are a waddling gait and difficulty in climbing stairs or in rising from the floor due to pelvic girdle muscle weakness. Later, shoulder girdle muscles become affected. The disorder progresses without remission until death occurs, usually within 10 to 15 years, although some patients live considerably longer.

A second type of muscular dystrophy, facio-scapulo-humeral muscular dystrophy, affects the muscles of the face and shoulders. It can be transmitted as a dominant trait. That is, if either parent carries the gene for this type of muscular dystrophy, each child born, male or female, has a 50 percent probability of being affected.

A third type, limb-girdle muscular dystrophy, affects the muscles of both the pelvis and shoulders. When both parents are carriers of the defective gene, each of their offspring has a 25 percent chance of inheriting the disorder and a 50 percent chance of being a carrier. Limb-girdle muscular dystrophy strikes between the first and third decade of life and its progress is sometimes rapid.

Variant types of muscular dystrophy also exist. Myotonic muscular dystrophy is an autosomal (not sex-linked) dominant disease beginning in young adulthood and characterized at first by stiffness in the limbs and inability to relax the handgrip, and later progressing to severe disability from muscle weakness and wasting. It also affects several other body tissues, including the heart, the lens of the eye, the testicles, and the brain.

Muscular dystrophy of late onset becomes noticeable in the fourth or fifth decade and affects both sexes. The first sign of the disease is weakness of muscles of the pelvic girdle. Its course is variable.

Diagnosis

Because a number of neuromuscular diseases that simulate muscular dystrophy can be treated successfully, accurate diagnosis of the specific type of muscular dystrophy is vital. Accurate diagnosis also facilitates evaluation of any treatment and aids the physician in his efforts to counsel the patient and his family.

The Muscular Dystrophy Association, Inc., through a nationwide network of 144 clinics, offers differential diagnosis free to anyone suspected by his physician to be suffering from muscular dystrophy or related neuromuscular disorders.

The accuracy of diagnosis is continually improving with the development of sophisticated tools through research. Diagnosis usually is based on the combination of clinical examination, family history, microscopic examination of muscle samples (biopsies), electromyography (recording of the muscle's electrical activity), and determination of levels of creatine phosphokinase (CPK), the enzyme that leaks out of damaged muscle tissue, in the blood.

Recently NINDS grantees at the University of Iowa developed a simple test to help diagnose Duchenne muscular dystrophy in newborns. The procedure, which measures creatine phosphokinase in a drop of dried blood, appears to be significantly more effective than standard CPK measurements. Preliminary evaluation on a small series of patients has yielded almost complete success. Standard CPK measurements achieve about 60 percent success. If this test is found to be as accurate as preliminary results indicate, it could be extremely valuable as an aid in counseling the carrier mother in her later pregnancies. However, as long as no definitive treatment exists, a postnatal diagnostic test is of much less value than a test applicable early in pregnancy. The search for a suitable test of this type continues.

Muscle biopsy has given scientists an accurate means of diagnosing various neuromuscular disorders as well as a valuable research tool to learn about muscle fibers in their normal and diseased states. Normal human muscle fibers are of two basic types--Type I and Type II fibers--which usually are evenly distributed. NINDS scientists have found that in myotonic dystrophy (a hereditary muscle disorder of young adulthood), there is a reduction in the size of Type I fibers and an increase in the size of Type II fibers. This change is relatively specific for myotonic dystrophy. They also found that in hypokalemic periodic paralysis (a disorder of the young characterized by attacks of weakness) there were no alterations in the Type I fibers, but Type II fibers showed atrophy in approximately half the cases.

Accurate and differential diagnosis is extremely important for several nonprogressive muscle disorders, because their course can vary dramatically and because both genetically dominant and recessive types are found. Diagnosis of this group of disorders, characterized by diffuse muscle weakness, is made almost exclusively by muscle biopsy because clinical signs are nonspecific.

A new technique called open-biopsy electromyography has been developed by NINDS scientists which allows, for the first time, a direct correlation of electrical activity with chemical analysis (histochemistry) of muscle fibers. With this procedure, the electromyography apparatus is brought into the operating room, the electrical activity of the muscle fiber is recorded, and the muscle tissue sample is excised and prepared for histochemical study.

Treatment

No real cure is known for any of the muscular dystrophies, but antibiotics have lengthened life in many patients through the control of infection. Physical therapy also has increased the mobility of these patients and has enabled them to lead more active lives. Of the many drugs tested for therapeutic use in muscular dystrophy, none has been able to retard or reverse the progression of the muscle weakening. Important nonspecific treatment includes physical therapy which may delay the shortening of the muscles; use of braces, walkers, special shoes, and corsets to compensate for muscle weakness; certain surgical procedures on muscles; special schooling, and special summer camps for afflicted children.

Because of the hereditary nature of Duchenne muscular dystrophy, prevention is most successfully accomplished by detection of the female carriers of the Duchenne gene and then providing genetic counseling before they bear children. Tests now can be performed to determine the sex of the fetus. If the unborn child is a male, a mother who knows she is a carrier can be alerted and given an opportunity to decide if she wishes to terminate the pregnancy.

Search for Underlying Cause

For many years the search for the causes of the various forms of muscular dystrophy has been directed toward the identification of abnormalities within the muscle. Recent work with muscle transplants in chickens led one investigator to conclude that development of dystrophy in chickens is due to a disorder of metabolism in the muscle cell. It is still not clear what relation animal dystrophies have to human dystrophies but clues may be provided to human disorders.

In the past few years NINDS investigators have introduced a new hypothesis for the cause of Duchenne muscular dystrophy. They believe that muscle damage may be produced by abnormalities of the small (arterial) blood vessels within the muscles rather than by a defect in the muscle itself. They further postulate that such blood vessel abnormalities may become apparent only when certain blood vessel constricting agents are present.

At the International Congress of Muscle Diseases held in September, 1974, in Newcastle, England, NINDS scientists presented the position paper for this hypothesis. Papers by other experimental workers either directly supported the possibility of this mechanism or were consistent with it. So far, there has been no work to contradict this concept, but, as the primary investigators emphasize, it remains a hypothesis.

The NINDS scientists also have reported pharmacological evidence to support their hypothesis. They were able to reproduce in rats the early and midstage characteristics of the disease both by tying off blood vessels and using drugs to constrict the vessels. Neither procedure alone, however, caused changes in the muscle fibers. They also found that following administration of the drug the serum muscle enzymes rise, as in Duchenne muscular dystrophy. These scientists now are using this test to screen for drugs that might be effective in preventing reduction of blood in the muscle. They recently demonstrated the effectiveness of three drugs in preventing muscle damage when given before the blood supply is restricted by the drug. These drugs, therefore, may be possible therapeutic agents for ischemic muscle diseases in humans.

A recent study by NINDS grantees reaffirms that a nonprogressive generalized mild or moderate decrease of intellectual function often coexists with Duchenne muscular dystrophy. The scientists speculate that a single gene, with expression in both muscle and brain, may be the cause.

A new technique for growing human skeletal muscle without neural influence in tissue culture has been developed by NINDS scientists in collaboration with investigators at New York University Medical Center. Tissue cultures provide unique opportunities for evaluation of growing muscle fibers without neural, vascular, and other influences that are operating in the patient. The observation of whether structural and chemical changes present in the patient's biopsied muscle fibers will or will not be reproducible in a tissue culture environment could help in explaining the progress of a given disease.

Evidence of a neuronal abnormality in a form of dystrophy seen in mice has been found by a British research team. They reported that dystrophic muscle behaves normally when regenerating in culture in the presence of normal spinal cord tissues but is abnormal when coupled with spinal cord samples from dystrophic mice. Whether there is a similar mechanism occurring in the human disease remains to be ascertained.

NINDS grantees have reported significant reduction in the activity of troponin, a protein that plays a crucial role in muscle contraction and relaxation. The decrease may be directly related to the impaired functioning of the affected muscle. In other muscle diseases, troponin activity remained normal.

NIH-supported scientists in Maine recently have observed that red blood corpuscles in patients with Duchenne muscular dystrophy leak potassium more rapidly than those of normal subjects. Similar findings in cells of the brain and liver of animals with a form of dystrophy indicate that Duchenne may be a disease of the cellular membrane and actually may be the result of this higher conductance of potassium.

NINDS-supported scientists at Duke University Medical School recently found evidence of a biochemical functional defect in the cellular membrane of muscle in myotonic muscular dystrophy. These findings indicate that this inherited disorder, which affects a number of organ systems, may result from an underlying cell membrane abnormality.

While many scientists have thought for a long time that myotonic dystrophy is essentially a disease of the muscle fiber, NINDS researchers are continuing to gather evidence that the muscle weakness and atrophy are caused by an abnormality of the motor nerve to the muscle rather than the muscle itself. This hypothesis, developed as part of the large effort by NINDS to differentiate between primary disorders of nerves and intrinsic muscle disorders, may redirect some of the research to uncover the precise cause of myotonic dystrophy and related disorders.

Research to Identify Carriers

Research has produced many significant advances which have simplified detection of carriers of Duchenne and have reduced the number of unidentified carriers. A new technique that may significantly enhance the precision of carrier identification in certain cases recently was developed by NINDS grantees. By coupling the new test, based on abnormal muscle protein synthesis, with creatine phosphokinase (CPK) measurements, the investigators were able to identify more than 90 percent of the Duchenne carriers, compared to between 66 percent and 80 percent using CPK evaluations alone.

In preliminary studies conducted by NINDS-supported scientists at Pittsburgh, the levels of an enzyme in the serum called pyruvate kinase (PK) were found to be 50 percent higher than CPK values in 29 carriers of Duchenne muscular dystrophy. The observation that the PK test is significantly more sensitive than the CPK test might be important in attaining a higher detection rate of Duchenne carriers. A broad screening study is required to support these provocative results.

Scientists recently reported that pregnancy may influence serum CPK levels. Since many carriers are first seen by physicians when they are already pregnant, the scientists suggest that normal values in suspected carriers during pregnancy should be interpreted with reservation, and the women retested after delivery.

The finding by NINDS scientists of degeneration and regeneration of scattered grouped muscle fibers in biopsy samples of Duchenne patients may serve as an additional indicator for detecting carriers. Electron microscopic observations of fibers reinforced diagnoses by other methods and identified cases in which no other laboratory evidence was available.

MYASTHENIA GRAVIS

Myasthenia gravis is a chronic neuromuscular disease characterized by weakness and abnormally rapid fatigue of the voluntary muscles, with improvement following rest. The disorder generally appears between ages 15 to 35 years in females, and ages 40 to 70 in males.

Research advances over the past two decades have resulted in significant reductions in the death rate and degree of illness in myasthenia gravis patients, even in the most severe cases. Improvements in support systems, such as intensive hospital care, respirators, and antibiotics, and widespread use of tracheostomy (surgery to open the windpipe) undoubtedly have contributed to the welfare of the myasthenia gravis patient. But the most dramatic advances center on the development of certain drugs that facilitate the transmission of nerve impulses across the nerve-muscle junction for muscle activation. In myasthenia gravis, transmission of this nerve-to-muscle impulse is defective in some way.

Formerly many myasthenia gravis patients died within the first few years of their illness. Today, scientists believe the majority of patients will live out a normal lifespan. Many patients cooperating with their physicians can expect to lead virtually normal lives.

Although the cause of myasthenia gravis is still debated, and therapy is directed toward symptoms, myasthenia gravis is one of the most successfully managed neuromuscular disorders.

Advances in Diagnosis

Diagnosis of severe myasthenia gravis usually can be made without difficulty on the basis of history and physical examination alone. Myasthenia gravis may affect any voluntary muscle, but usually involves those of the eyes, face, lips, tongue, throat, and neck more severely than others. Involvement of muscles of breathing and limb movement also can be severe.

Symptoms may vary depending upon which muscles are affected. The disease may begin with a localized weakness, or as a severe generalized weakness. A patient may experience difficulties in breathing, swallowing, or talking, or have double vision, or arm or leg weakness. There may be unusually rapid muscle fatigue following repetition of a movement.

Diagnosis can be confirmed with drug studies as well as with electrical, mechanical, and X-ray tests. Injection of a drug that facilitates nerve-muscle message transmission may result in a dramatic increase in strength. Administration of a compound that blocks the transmission of nerve-muscle messages causes increased weakness. Response to these agents usually confirm the diagnosis of myasthenia gravis.

In the past year NINDS scientists have developed a new diagnostic test involving the intravenous infusion of a lactate compound. Injection of this compound has produced significant decreases in various voluntary muscle functions, including respiration, voice, grip, and movements of eyelids in a series of patients. The investigators conclude that this appears to be a reliable test and is somewhat safer than the generally used curare test for evoking the myasthenic weakness.

Study of the thymus, (a gland-like organ in the chest that normally atrophies with increasing age) is often valuable. If there is diagnosis of tumor of the thymus in myasthenia gravis patients, this will have important bearing on both the treatment and outcome of the disease. Moreover, the role of the thymus in causing the disease is of increasing research interest.

Advances in Treatment

Basic research has produced an increasingly precise picture of the mechanisms by which nerve impulses are transmitted for muscle activation. This information has led to refinements in treatment. Several drugs provide relief from symptoms, and others may be effective against one or another cause. For nearly four decades the anticholinesterases, especially pyridostigmine and neostigmine, have been the mainstays of symptomatic treatment.

ACTH Therapy. There is substantial documentation that treatment with ACTH (adrenocorticotrophic hormone) benefits severely ill patients. One of the disadvantages of this therapy earlier found by NINDS grantees was that many receiving a 10-day course of daily ACTH experienced temporary muscle weakness and increased difficulty in breathing for the first several days before improvement began to appear. Paradoxically, the patients who experienced the greater initial weakness usually showed the more striking eventual recovery. Continued maintenance ACTH injections every few days or weekly recently were found to prolong the beneficial effects. NINDS grantees also have found that short intensive courses of ACTH are useful in improving temporary weakness.

Prednisone Therapy. NINDS scientists continue efforts to expand on their development of a new treatment--a high, single dose, alternate-day, oral prednisone regimen--which has proven extremely beneficial over long periods in the majority of patients tested. Prednisone is a synthetic drug that acts similarly to the natural hormone, cortisone. Patients over age 40, especially males, appear to respond best to this treatment. Physicians throughout the world have confirmed the beneficial results. In fact, NINDS scientists now consider alternate-day prednisone the most effective treatment and believe it may suppress the disease sufficiently long for it to disappear.

Institute scientists recently demonstrated in animal nerve-muscle preparations an adverse interaction between prednisone and anticholinesterase drugs. These findings may help explain why the condition of some myasthenics taking both drugs becomes aggravated. This possibility has led some scientists to decrease or discontinue the use of anticholinesterases before administering steroids. Many myasthenia gravis patients have been managed successfully with the two drugs used together, however.

Thymectomy. Thymectomy (surgical removal of the thymus) was found by NINDS-supported scientists to be beneficial in nearly 90 percent of a large patient series, most of whom were severely affected. These data plus the positive results from several additional studies have convinced some scientists that thymectomy should be performed routinely on all myasthenia gravis patients, especially younger females.

New Agents. A group of drugs known as the germine acetates are being evaluated for their effectiveness in managing myasthenia gravis. An early report noted that patients treated for a short time exhibited improved neuromuscular function. More recently, other investigators reported favorable results from use of germine monoacetate (GMA) for outpatients over a limited time.

Theories on Cause

The cause of myasthenia gravis continues to elude scientists, but there is agreement that the problem exists somewhere along the motor unit, which consists of the lower motor neuron (a branching nerve fiber), and the muscle fiber it activates. Many studies have centered on the junction between the tip of the nerve and the muscle fibers, where nerve impulses liberate a chemical, acetylcholine, which transmits the impulse causing the muscle fibers to contract.

Myasthenia gravis may result from a failure of the neuron to make acetylcholine, or from a disturbance in its release. It also is possible that myasthenia gravis is due to the presence of inhibiting substances in the patient's blood.

There is recent evidence to support an additional hypothesis for the transmission failure--namely that myasthenia gravis may be an autoimmune disturbance in which circulating antibodies attack and damage the patient's own tissue. It recently was demonstrated that one-third of myasthenia gravis patients have circulating antibodies against skeletal muscle and the thymus. These antibodies are found in virtually all myasthenia gravis patients with thymus tumors and in some who do not have myasthenia gravis but do have the tumors. It is now believed that antibodies do not cause the symptoms of the disease but are an indicator of a parallel autoimmune disturbance.

NINDS investigators now hypothesize that the defect of transmission located at the neuromuscular junction possibly is secondary to and caused by an aberration in the metabolism of the nerve cell body. They suggest that a circulating factor from the thymus and related tissue may be exerting the detrimental influence.

Analysis of the receptor protein at the neuromuscular junction has shown that it is distinct from the anticholinesterase molecule in mammalian muscle. Previously this had been shown only in lower species, such as electric eels. This finding helps clarify the molecular mechanisms in neuromuscular transmission and hopefully will give scientists added insight.

A new method for accurately identifying skeletal muscle fibers that have lost normally accompanying nerve fibers has been developed by NINDS scientists. This technique is directly applicable to investigating the influence of partially or completely interrupted motor neurons on muscle fibers in myasthenia gravis and offers a new approach to the study of neuromuscular diseases. By injecting a radioactive compound in the spinal fluid and spinal cord, they have found the compound is taken up by the motor nerve cells and is converted into a specific protein. The protein flows down the motor nerve and accumulates at the nerve-muscle junction. This is the first step to demonstrate that protein crosses to the muscle to serve as a nutrient factor.

Investigators at The Johns Hopkins University recently reported a reduction in the number of acetylcholine receptors in the neuromuscular junctions of eight myasthenia gravis patients. This reduction may account for the defect in neuromuscular transmission.

While evaluating a receptor protein from the neuromuscular junction, NINDS grantees found that rabbits injected with the protein developed weakness and paralysis resembling some aspects of human myasthenia gravis. Further evaluation of this new animal model possibly might help clarify the progress of myasthenia gravis and contribute to improved treatment.

POLYMYOSITIS/DERMATOMYOSITIS

Two muscle diseases, quite similar to muscular dystrophy and sometimes misdiagnosed as muscular dystrophy now are treatable. Polymyositis and dermatomyositis are inflammatory disorders of the muscle and skin, characterized by elevated muscle enzymes, such as creatine phosphokinase (CPK), circulating in the serum. These disorders, if left untreated, often are steadily progressive and fatal.

NINDS scientists find that the high single dose, alternate-day, prednisone regimen, which they instituted for the management of this disorder complex seven years ago, continues to be effective in the majority of patients. In some patients who do not respond to corticosteroid therapy, Institute scientists have found that addition of azathioprine, an immunosuppressant drug, produces beneficial results.

These investigators are able now to demonstrate, by the study of lymphocytes (a variety of white blood corpuscles) in these patients, the degree to which lymphocyte function is controlled or inhibited by the drugs. A distinct "on-day"/"off-day" effect has been demonstrated showing a pattern of inhibition of lymphocytic function during the "on-day" of prednisone with a gradual increase during the "off-day" when prednisone is not given. This is a basic test which now can be used to compare patients who are responding and who are not responding to prednisone.

Evidence of an immune reaction causing vascular injury in dermatomyositis of childhood, which earlier was reported by NINDS scientists, has now been confirmed by others.

DISCOVERY OF NEW DISEASES

Since the report last year of a rare new myopathy--carnitine deficiency--by NINDS grantee investigators in Minnesota, several new cases have been discovered. Carnitine, a component of muscle tissue, was found to be absent in the skeletal muscle of patients with progressive muscle weakness. The scientists believe they have uncovered this year a second type of carnitine deficiency disorder which can mimic primary liver disease. Prednisone therapy has been shown to improve the patients' weaknesses. The reason for the carnitine deficiency is not known.

NINDS scientists, in collaboration with investigators at the National Cancer Institute, recently uncovered in a family of patients an entirely new mechanism for a hereditary sensory neuropathy never before seen. A sensory neuropathy is a disturbance of the peripheral nervous system, characterized by lightning pains and loss of cutaneous sensation. The patients were found to have an elevated production of an immunoglobulin protein (IgA) in their intestinal tract. The investigators hypothesize that a local infection in the intestinal tract, which occurs through hereditary predisposition, actually causes the neuropathy--perhaps by preventing absorption of the proper substances from the food or by manufacturing toxic substances. Whatever the mechanism, this finding

raises the interesting possibility of a link between the intestinal tract and the actual neuropathy in this hereditary disease.

NINDS scientists have recently reported that repeated injection of drugs into the muscle can produce muscle degeneration resulting in what they have termed levitated arm syndrome. This disorder, which can be misdiagnosed as muscular dystrophy, can be prevented by stopping the injections in the muscle. Even if the disorder has progressed to the point where the arms are stuck in an upwardly fixed position, it can be treated successfully with surgery.

Spinocerebellar ataxias represent a broad group of diseases characterized by failure of muscular coordination. In two families with one of these diseases, called Friedreich's ataxia, NINDS scientists recently found evidence of a genetic disorder involving a defect in a metabolic function. Although this finding does not provide the cause of the spinocerebellar degeneration characteristic of the disease, it does give researchers a new biochemical approach to the actual metabolic defect damaging the nervous system.

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OFFICE OF HUMAN DEVELOPMENT

Rehabilitation Services Administration

Because of the nature of the disease, victims of muscular dystrophy have limited potential for gainful employment, and therefore only a small number of them have been rehabilitated through the State-Federal program of vocational rehabilitation. It is hoped, however, that the acquisition of new medical knowledge concerning this disabling condition will contribute to positive gains over the next decade in the work capacity of the muscular dystrophy case. State vocational rehabilitation agencies will be serving increased numbers of persons disabled by muscular dystrophy due to the emphasis in the Rehabilitation Act of 1973 on serving the severely disabled.

Research in the Rehabilitation Research and Training Centers that pertains to Muscular Dystrophy addresses the limited potential for gainful employment due to the diminished or total loss of function in the muscles, or to the medical complications that accompany the disease. Examples of this type of research include a study of lung expansion in patients with muscular dystrophy to prevent recurring hospitalization, a study of the structure and ultrastructure of the muscles in neuromuscular diseases such as muscular dystrophy, the effects of submaximal exercise in strengthening the muscles in muscular dystrophy, and the effects of hormonal agents in muscular dystrophy. With the discovery of new knowledge and the development of techniques and procedures that will improve muscle function and treatment of muscular dystrophy, more patients afflicted with the disease can be vocationally rehabilitated.

Rehabilitations with Muscular Dystrophy

Fiscal Year Ending June 30	Persons Rehabilitated	
	Total	Muscular Dystrophy
1972	326,138	313
1973	360,726	328
1974	361,138	400
1975	363,000	650
1976	332,000	800

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

ACTIVITIES SERVING OLDER AMERICANS

1974

In response to the many social, health, economic, education, and other needs of the Nation's elderly, a wide range of programs serving this age group were administered during 1974 by various agencies throughout the Department of Health, Education, and Welfare. This report begins with a tabular summary of actual and expected yearly expenditures for activities on behalf of older Americans of each HEW agency which administers one or more major programs serving this segment of the population. This is followed by narrative descriptions, in the following order, of these activities:

I. Office of Human Development

- A. Administration on Aging
- B. Rehabilitation Services Administration
- C. Office of Rural Development
- D. Office of Native American Programs

II. Social Security Administration

III. Public Health Service

- A. Health Services Administration
- B. National Institute of Child Health and Human Development
  National Institutes of Health
- C. Alcohol, Drug Abuse, and Mental Health Administration
- D. Health Resources Administration

IV. Social and Rehabilitation Service

- A. Assistance Payments Administration
- B. Community Services Administration
- C. Medical Services Administration
- D. Office of Planning, Research, and Evaluation

V. Office of Education

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Funds for Programs on Aging
(In thousands of dollars)

I. Office of Human Development	1972 Actual	1973 Actual	1974 Actual	1975 Estimate	1976 Estimate
A. Administration on Aging					
Development of programs for the Aging	$44,552	$83,737	$306,136	$196,100	$196,100
Aging research and training	12,500	12,100	16,500	7,000	7,000
Total, Administration on Aging	67,052	95,737	322,636	203,100	203,100
B. Rehabilitation Services Administration					
Basic State Grants	8,960	8,835	11,340	12,240	12,240
Facility Improvement	200	154.5	149.4	140.13	124.2
Total, Rehabilitation Services	9,160	8,989.5	11,489.4	12,380.13	12,364.2
Rehabilitation Training	44.32	41.55	28.03	28.03	39.96
Total, RSA	9,204.32	9,031.05	11,517.43	12,408.16	12,404.16
C. Office of Rural Development	---- 1/	---- 1/	17.25 2/	22.2 2/	24.4 2/
D. Office of Native American Programs	---- 3/	---- 3/	188	188	188
Total, Office of Human Development	$76,256.32	$104,768.05	$334,358.68	$215,718.36	$215,716.4
II. Social Security Administration					
Benefit payments to persons age 65 and over from Social Security trust funds:					
Disability insurance benefits (Dependents).....	$17,000	$21,000	$24,000	$28,000	$35,000
Retirement and survivors' insurance benefits.....	27,165,000	33,247,000	37,898,000	43,480,000	50,039,000
Hospital insurance benefits	6,108,000	6,648,000	7,310,000	9,031,000	10,305,000
Supplementary medical insurance benefits	2,255,000	2,391,000	2,587,000	2,960,000	3,380,000
Sub-total, benefit payments to persons age 65 and over from social security trust funds	35,545,000	42,307,000	47,819,000	55,499,000	63,759,000

1/ No figures are available.
2/ Figures are unreliable estimates only.
3/ During FY 1972 and FY 1973, ONAP was in the Office of Economic Opportunity.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Funds for Programs on Aging
(In thousands of dollars)

II. Social Security Administration (Continued)

Payments to persons age 65 and over from Federal funds:

	1972 Actual	1973 Actual	1974 Actual	1975 Estimate	1976 Estimate
Supplemental Security Income payments	---	---	850,000	1,860,000	2,090,000
Special benefits for disabled coal miners	271,000	612,000	664,000	673,000	735,000
Sub-total, payments to persons age 65 and over from Federal funds	271,000	612,000	1,514,000	2,533,000	2,825,000
Grand Total, Social Security Administration	$35,816,000	$42,919,000	$49,333,000	$58,032,000	$66,584,000

III. Public Health Service

A. Health Services Administration					
1. Community Health Services	$30,502	$31,431	$25,975	$20,800	$20,800
2. Medical Care Standard	4,719	4,719	5,613	5,775	4,537
3. Professional Standards Review Organization	none	4,475	12,805	18,102	25,072
Subtotal, Health Services Administration	35,221	40,625	44,393	44,677	50,409
B. National Institute of Child Health and Human Development (National Institute on Aging)	12,505 4/	12,650 4/	17,203 4/	13,300 4/	16,190
C. Alcohol, Drug Abuse, and Mental Health Administration					
National Institute of Mental Health	4,516	2,894	2,128 (2,487) 5/	2,240 (2,421) 5/	2,434
D. Health Resources Administration					
1. National Center for Health Statistics	$ 926	$ 900	$ 872	900	1,100
2. National Center for Health Services Research	10,133	5,396	5,322	3,600	3,000
3. Bureau of Health Resources Development, Division of Facilities Utilization	61,240	41,762	38,953	45,966	43,993
Subtotal, Health Resources Administration	72,299	48,058	45,147	50,466	48,093
Total, Public Health Service	$114,541	$104,227	$108,871 (109,230) 5/	$110,683 (110,864) 5/	$117,126

4/ Figures for 1972 through 1975 represent the portion of the appropriations for NICHHD which was and is being allocated to its aging program or to the National Institute on Aging.

5/ Includes 1973 released funds.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Funds for Programs on Aging
(In thousands of dollars)

	1972 Actual	1973 Actual	1974 Actual	1975 Estimate	1976 Estimate
IV. Social and Rehabilitation Service					
A. Assistance Payments Administration.....	$1,297,519	$1,287,752	$635,409 6/	$25,707 7/	$3,670 7/
B. Community Services Administration.....	170,000	216,000	231,000 8/	306,000	334,000
C. Medical Services Administration.....	1,778,348	1,539,398	2,247,541	2,647,945	3,059,787
D. Office of Planning, Research and Evaluation.....	280	125	138	1,613	5,300
Total, Social and Rehabilitation Service.....	$3,246,147	$3,043,275	$3,114,088	$2,981,265	$3,402,757
V. Office of Education					
A. Library Resources.....	$1,015	$550	$750	$600	----- 9/
B. Adult Education.....	1,534	1,800	5,630	5,630	5,630
C. University Community Services.....	121	130	130	None	None
Total, Office of Education..	$2,670	$2,480	$6,510	$6,230	------ 9/

6/ Includes one half-year payments and costs for programs affected by P.L. 92-603.
7/ Adult programs in Guam, Puerto Rico, and Virgin Islands only.
8/ Estimate
9/ Not available at time of printing.

I. OFFICE OF HUMAN DEVELOPMENT

A. ADMINISTRATION ON AGING (AoA) - CALENDAR YEAR 1974

1. INTRODUCTION

The year 1974 was a period of transition for the Older Americans Act, marking the first full operational year after enactment, on May 3, 1973, of the Older Americans Comprehensive Services Amendments of 1973 (P.L. 93-29). In fulfillment of this new mandate, the Administration on Aging (AoA) has identified two major goals toward which its immediate and long-range efforts will be directed, and its work during the year emphasized these goals.

The first goal is to increase State and Area Agency on Aging capacity to:

- develop and implement annual operational plans to enable older persons to remain in their own homes or other places of residence;
- identify available resources;
- set priorities for action programs;
- coordinate existing services for older persons and pool available but untapped public and private resources for the support of services;
- promote the development of supporting services, such as information and referral and transportation; and
- promote the development of other social services for older persons as defined in the Older Americans Act.

The second major goal is to increase the capacity of the Federal sector to promote comprehensive coordinated services for older persons through coordination of plans and programs which affect this segment of the population. AoA's interagency efforts are being directed at tapping those Federal resources which can be brought to bear in developing and strengthening at the sub-State level a comprehensive system of coordinated services for older people.

Under its new organizational structure, which became effective in 1974, the Administration on Aging is composed of the following constituent units: (1) The Immediate Office of the Commissioner on Aging; (2) The Office of Planning and Evaluation; (3) The Office of State and Community Programs: (4) The Office of Research, Demonstrations and Manpower Resources; (5) The National Clearinghouse on Aging; (6) The Field Liaison Staff; and (7) The Nursing Home Interests Staff.

The Office of Planning and Evaluation (OPE) carried out five-year forward planning activities, various evaluation activities, and legislative and policy analysis functions. OPE's legislative analyses make it possible for AoA to keep advised of bills, hearings, and other phases of the work of Congress, and their effect or potential effect on older persons. In this connection, AoA's legislative staff keeps an up-to-date compilation and analysis of all proposals pertinent to older persons which are introduced in the Congress.

Examples of OPE's policy analysis activities in 1974 included an on-going, in-house analysis of major issues related to the conduct of programs under Titles II, III, IV, and VII of the Older Americans Act, as amended; an intensive, ongoing analysis of the effects of the energy shortage on older persons ; an analysis of issues relative to the Supplemental Security Income Program, and other activities under Titles I, X, XIV, XVI of the Social Security Act, in particular, health care services under Medicare and Medicaid. Also initiated was

a staff study of the status of social and health services definitions. The in-house study has indicated the need for uniform definitions of services and development of national standards for the measurement of the delivery of such services to assure meaningful assessment of program progress.

The Office of State and Community Programs (OSCP) serves as the focal point for development and assessment of the State and Community Programs on Aging (Title III) and the Nutrition Program for the Elderly (Title VII). It maintains information on programs of other Federal agencies and national voluntary agencies which have potential for relating to State and Area Agency on Aging planning and implementation of services for older people. In addition, OSCP develops regulations, policies, and guidelines for use by State and Area Agencies on Aging; develops optional models and disseminates "best practice" suggestions for use by the Regional Offices, State Agencies on Aging and Area Agencies on Aging; develops and monitors, in cooperation with other AoA units, management information and reporting systems which provide updated information to facilitate planning and program adjustment for management efficiency at all organizational levels; and carries out other related functions.

AoA's Office of Research, Demonstrations and Manpower Resources serves as a focal point for coordination of research on aging by Federal agencies; provides the chairman and secretariat services to the Interagency Task Force on Aging Research, under the Interdepartmental Working Group of the Cabinet-level Domestic Council Committee on Aging; develops policy, supports projects and monitors progress related to research, demonstration, and manpower resources programs under Title IV of the Older Americans Act; and carries out other functions supportive to AoA's mandate to provide national leadership and expertise in encouraging new knowledge and upgrading competencies in the field of aging.

AoA's National Clearinghouse on Aging serves as the focal point within the Federal Government for the collection, analysis, and dissemination of information related to the needs and problems of older persons, and, wherever possible, develops and coordinates programs with other offices and agencies to fill gaps in information in the field of aging; produces a variety of professional and lay publications and audiovisual material on aging; publishes AGING magazine; develops special information campaigns; responds to numerous letters and telephone inquiries; and performs other related functions in the area of public information.

AoA's Field Liaison Staff assists Regional offices in keeping informed of continuing developments relative to the objectives and programs of the Administration on Aging; identifies difficulties being encountered by Regional offices in carrying out their duties and responsibilities; defines priorities and expectations to resolve or prevent conflicting workload demands placed on AoA staffs; ascertains the degree of further assistance required from AoA Headquarters to ensure that Regional offices achieve national and operational planning objectives; and provides other related assistance to Regional office staff.

The Nursing Home Interests Staff, established in 1974 to meet additional responsibilities assigned to AoA in the long term care area, provides technical assistance to community and advocacy groups which are working for the improvement of long term care, assists in the development of new alternatives to institutional care in collaboration with other agencies, serves as project manager for the Nursing Home Ombudsman Demonstration Program, and provides technical assistance in the area of nursing home patient relocation.

In addition to completing its first full operational year under new legislative initiatives and internal organizational arrangements, AoA also completed its first full operational year as a component of the Office of Human Development (OHD) within the Office of the Secretary of HEW. As a part of this new

office, AoA has the advantage of working in close association with other OHD components which have responsibilities for the planning and delivery of services for special populations which overlap with AoA target groups, including those of low income and racial minority status.

The remainder of this report provides detailed information relating to activities carried out during 1974 and January of 1975 under the Older AmericansComprehensive Services Amendments of 1973, major program initiatives, and indications of anticipated developments for the remainder of 1975.

2. STATE AND COMMUNITY PROGRAMS ON AGING

In fiscal year 1974, Federal grants to States for area-wide programs of services to older persons were implemented in accordance with Title III of the Older Americans Comprehensive Services Amendments of 1973.

Prior to the Amendments of 1973, the Older Americans Act provided support for discrete services designed to respond to particular needs of older persons in scattered local communities. Under the 1969 Amendments, a program of Areawide Model Projects was initiated to test the viability of providing a network of coordinated service systems to serve older persons. Building upon the most successful experiences of these projects, the 1973 Amendments were designed to develop a national initiative directed toward providing comprehensive systems of services which will coordinate available and potential services and resources on behalf of older persons.

a. State Planning, Coordination, Administration, and Evaluation

The Title III Program has as one purpose the strengthening of State Agencies on Aging to discharge, among others, the following responsibilities:

-- to become a focal point in the State on behalf of older persons;

-- to carry out those activities necessary for effective planning on behalf of older persons, including the establishment of measurable objectives for aging programs;

-- to establish such procedures and mechanisms as are necessary to assure the effective coordination of all State planning and service activities related to the field of aging;

-- to provide for ongoing monitoring and assessment and to conduct periodic evaluations of activities and projects in the field of aging, with special emphasis on the work of Area Agencies on Aging; and

-- to assure, in cooperation with Area Agencies on Aging, the availability of information and referral sources in sufficient numbers so that all older persons will have reasonably convenient access to such sources by the end of Fiscal Year 1975.

To be eligible for grants under Title III, States are required to submit annual State Plans on Aging to the Commissioner on Aging for approval. These plans are developed by the designated State Agency on Aging and submitted by the Governor of each State. Each State Plan must identify the objectives which the State proposes to achieve during the year, and the plans of action which the State will implement for such matters as provision of technical assistance, monitoring of programs, conduct of coordination and pooling activities, provision of manpower development and training, and establishment of information and referral resources. The State Plan must also identify the manner in which the State has been divided into planning and service areas, the determination of which of these areas will have designated area agencies, and the manner in which resources will be allocated under the program.

In 1973 and 1974 State Agencies on Aging conducted Statewide surveys of their older population to determine the concentration of older persons with the greatest social and economic need and to assess the availability of resources to meet the identified needs. As a result of these surveys, State Agencies on Aging designated 621 Planning and Service Areas (PSA). By the end of 1974 412 Area Agencies on Aging had been established within PSA's of highest priority to administer Area Plans for comprehensive and coordinated services for older persons.

During 1974, State Agencies' resources were directed toward the implementation of the approved State Plans on Aging for Fiscal Year 1974 and the development and implementation of State Plans for Fiscal Year 1975. The activities under the 1974 State Plans focused on establishing at the State level mechanisms for achieving coordination between Title III and other planning and services programs related to the purposes of the Older americans Act; establishing State advisory committees on aging; establishing the 412 Area Agencies on Aging, which cover seventy percent of the older population nationally, and approval of area plans on aging developed by these agencies; assisting in the development of agreements for coordinated activities between Area Agencies and the District Offices of the Social Security Administration; developing information and referral sources; and ensuring that at least one-half of the older persons who are recipients of services in areas where Area Agencies are located are those who come within the two primary target groups of this program the low-income and minority elderly.

State Plans on Aging for Fiscal Year 1975 have been reviewed and approved. FY'75 State Plans include objectives related to the development of State level capabilities for technical assistance to Area Agencies on Aging and nutrition projects under Title VII, and for monitoring and assessment of these programs; the negotiation of formal inter-agency agreements with the Social Services agency in each State; the development of other resources to increase the number of meals served in congregate settings; the establishment of additional Area Agencies on Aging; and the development of information and referral sources which meet standards established by the Administration on Aging. In addition to these efforts, State planning activities include action programs for the involvement of minority agencies and organizations in the delivery of services under Title III and Title VII; steps to assure equal employment opportunities for minorities, women and older people at the State and area levels; and actions designed to assist older persons who face problems associated with the energy crisis.

In FY'74 State Agencies received $12 million for State planning, coordination, administration and evaluation. The President's budget request for FY 1975 included $15 million for this activity.

b. Area Planning and Social Services

Title III establishes a program intended to address the failure in most communities to systematically pool the resources and services that are available for older persons and to focus them in such a manner as to make a significant impact on the lives of older persons. Title III calls for the development of a national network of agencies which are to be designated by the States as Area Agencies on Aging. The law provides that the State may designate a public or non-profit private agency or organization as an Area Agency on Aging. The State is required, however, to give preference to an established office on aging where one exists.

The majority of the 412 Area Agencies on Aging established in 1974 are located within city or county governments or within regional councils of government.

Forty-seven percent are located in rural areas; fifty-three percent in urban areas.

Area Agencies on Aging are required to submit an Area Plan to the State Agency on Aging for approval.

The Area Plans were developed and approved in accord with the following specifications:

- a plan of action for discharging the responsibilities set forth in the legislation;
- an operating plan that will give priority to those activities and services which will assist and benefit low income and minority older persons throughout the planning and service area, and will assure, to the extent feasible, that low income and minority individuals will be served at least in proportion to their relative numbers in the planning and service area;
- a plan for bringing about maximum possible coordination between the resources available in the planning and service area under Title III and those available under the Adult Services and Medical Care Titles of the Social Security Act;
- a plan for demonstrating to local governmental units how the priority established under General Revenue Sharing for social services for the poor or aged can be used in such a manner as to inaugurate new or strengthen existing services for older persons;
- a plan for endeavoring to work out arrangements under which recipients of grants or contracts for nutrition projects mutually agree with the area agency that such nutrition projects shall be made a part of the area's coordinated and comprehensive service system for older persons.

In Fiscal Year 1974, $68 million was appropriated for Area Planning and Social Services. The President's budget request for FY 1975 included $76 million for Fiscal Year 1975.

During the 1975-1976 period increasing emphasis will be placed on the monitoring and assessment of the Title III program, as States come closer to meeting their objectives regarding the establishment of Area Agencies on Aging in all priority planning and service areas. A Cummulative Quarterly Progress Report for Older Americans' Act Programs has been developed and will be implemented in the States during the last quarter of FY'75. Development of uniform standards regarding the planning and delivery of services to older persons will also be given increased attention.

c. Statewide Model Projects

Title III also authorizes the Commissioner on Aging, after consultation with the State Agency on Aging, to enter into contracts with or make grants to any public or non-profit agency or organization within a State to pay part or all of the cost of developing or operating Statewide, regional, metropolitan area, county, city or community model projects which will expand or improve social services or otherwise promote the wellbeing of older persons.

During 1974, $12 million was awarded to State Agencies to conduct Statewide Model Project efforts. State Agencies earmarked over twenty-five percent of the funds awarded to support activities designed to ensure that all older persons will have reasonably convenient access to information and referral sources. These included initiation of Statewide, toll-free WATS lines; expansion and automation of needs and resources survey data; development of inter-agency infor-

mation systems for the integration of services; and preparation of manuals and procedural guidelines to train professionals and volunteers in information and referral counseling. State Agencies also earmarked funds for the continuation of SSI-ALERT to inform older persons of their potential eligibility for participation in the SSI program. Other activities receiving support included transportation, homemaker, housing, health care, education, legal, day care, and employment services.

d. Nutrition Program for the Elderly (Title VII)

Title VII of the Older Americans Act of 1965, as amended, the Nutrition Program for the Elderly, was implemented in fiscal year 1974. This Title authorizes the Commissioner on Aging to make formula grants to States to establish and maintain community-based nutrition projects for the delivery of low cost, nutritious meals, served primarily in congregate settings and with supportive social services, to persons 60 years of age or over and their spouses. Each Title VII project must provide at least one hot meal per day, five or more days per week. Supportive social services include outreach, transportation, information and referral services, health and welfare counseling, nutrition education, and recreational activities.

The program is designed to assist communities to meet the nutritional and social needs of older persons who do not eat adequately because: (1) they cannot afford to do so; (2) they lack the skills to select and prepare nourishing and well-balanced meals; (3) they have limited mobility which may impair their capacity to shop and cook for themselves; (4) they have feelings of rejection and loneliness which obliterate the incentive necessary to prepare and eat a meal alone.

The Nutrition Program operates within the same conceptual framework as Title III, since the delivery of low cost meals and related services is one component of a comprehensive coordinated services system. State and Area Agencies on Aging are urged to work out mutually satisfactory agreements with grantees under Title VII designed to integrate the nutrition projects into area service systems, and to bring about meaningful coordination between them and the providers of services under Title III.

The utilization of other public resources is being accomplished through interdepartmental agreements at the national level, including those of the Interdepartmental Task Force on Nutrition, and at the State and local levels. Federal regulalations require maximum utilization by Title VII grantees of all other existing public and private resources in the conduct of the program.

In fiscal year 1974, State Plans for the Title VII program were approved and $98,600,000 was allotted to the States for this program. Six hundred and sixty-five (665) nutrition projects have been approved. Of this number, 72 per cent are located in urban areas, and 28 per cent are in rural areas. Approximately 220,830 meals are being served daily at some 4,100 sites. According to periodic reports from the States, 64 per cent of the meals being served are to older persons below the poverty threshold, and 32 per cent are served to minority older persons. These projects vary widely in size and scope of operations.

New authorizations are provided by Public Law 93-351, signed by the President on July 12, 1974, which provided for a three year extension of the program.

In addition $35,000,000 was authorized in the new Section 309 of Title III, added by the 1974 amendments to the Older Americans Act (P.L. 93-351) for the purpose of providing "supportive transportation services in connection with nutrition projects"... No appropriations have been enacted for this activity at this time. However, under existing laws and regulations, 20 percent of the Title VII State allocations may be used for supportive services, including transportation. A number of projects are supporting major transportation activities.

During 1974 States concentrated heavily in getting the projects started and serving meals to older people. Monitoring and assessment of progress toward meeting all of the objectives of Title VII, including the coordination and supporting services aspects of the program, will be emphasized in 1975.

e. Advisory Councils and Committees

To actively promote the interests of older persons, establishment of advisory councils and committees at the State and local level is specifically required by the Older Americans Act.

At the State level, State Plans include, as one of their objectives, the establishment of an Advisory Committee to the Governor and the State Agency on Aging. At least one-half of the membership of this committee is to be composed of older consumers of services, including low income older persons and minority group older persons, at least in proportion to the number of minority older persons in the State. Other members are to be representative of major public and private agencies and organizations who are experienced in or have particular interest in the needs of older persons.

At the area level, the Area Agency on Aging is also required to establish an Area Advisory Council. Members are to be representative of program participants and the general public, including low income older persons, and minority older persons at least in proportion to the number of minority older persons in the area. At least one-half of the membership of the Area Advisory Council is to be made up of older consumers of services. The function of the council is to advise the Area Agency on Aging in regard to the development and administration of the Area Plan and activities conducted under it.

For the Title VII nutrition program, States are required to indicate in their State Plans provision for advisory assistance from older consumers of nutrition services and others knowledgeable about nutrition. At the local level, each nutrition project is required to have a Project Council, with one-half of its membership consisting of participants of nutrition services. Other members of the council include persons competent in the field of nutrition services and in the needs of older persons. The project councils have wide responsibilities in all matters relating to the delivery of nutrition services and all policy matters of the project. Where a nutrition project is located within a planning and service area for which an Area Plan has been developed, a representative of the nutrition project council must be included in the Area Advisory Council.

3. FEDERAL COORDINATION ACTIVITIES

The Older Americans Act, as amended, assigns responsiblities to the Administration on Aging to serve as a focal point within the Federal Government in matters pertaining to problems of the aged and aging. In pursuing its broad legislated responsiblities as the Federal focal point for aging matters, AoA seeks:

(1) To improve interagency coordination of plans and programs which affect older persons;

(2) To generate and analyze information pertinent to the problems of the aged and aging;

(3) To assess the progress and problems of programs which affect older persons with a view toward designing new strategies for improved program effect.

(4) To direct initiatives in aging programming and supporting research to meet demonstrated needs of the elderly;

Within the Department of Health, Education, and Welfare, AoA's responsibility for improving Federal coordination and program effectiveness on behalf of the aged is organizationally strengthened by AoA's relationship to the Office of the Assistant Secretary for Human Development. Through that office, AoA is granted organizational responsibility within the Department for advising the Secretary on matters dealing with the aged, recommending actions for improving coordination and government-wide effectiveness, and ensuring that other Department programs also recognize and serve the needs of this special population group.

The current long-range strategy of the Administration on Aging is to direct its limited resources primarily in support of its program management roles under Titles III and VII. In regard to its research, information, evaluation, training and technical assistance functions, as well as in its implementation of the Title III and Title VII programs, AoA attaches high priority to identifying and pursuing those interagency activities which will contribute toward achievement of coordinated, comprehensive services for older people at the local level.

Principal emphasis is being placed upon development of a national knowledge base on aging and coordination of those resources which currently or potentially impact on AoA target group populations. In the near future, priority attention will be directed at improving the delivery and utilization of specific services for the elderly, in particular the low-income impaired and minority elderly, through joint agreements and programming with SRS, SSA, and PHS, in such areas as I&R, adult social services, Medicaid, rehabilitation services, community health and mental health services, and comprehensive health planning. With additional program experiences and continuing analyses, AoA will be in a position to identify other specific services needed by the elderly which cannot be developed through the State and Area Agency structure alone and which require new Federal initiatives. Barriers to increased cooperative programming will be identified, as well as infrastructural changes and interagency mechanisms and authorities which are necessary to facilitate AoA's full assumption of its broader Federal focal point role.

In carrying out its focal point activities during 1974, AoA has sought to develop the potential for coordinated planning and programming inherent within the Committee on Aging of the Cabinet-level Domestic Council, the Federal Regional Councils, and the Federal Executive Boards. In addition, AoA has built upon previously existing interagency agreements and authorities, and has moved to implement its responsibility within the Department for improving Departmental coordination and effectiveness on behalf of the aged.

AoA believes that significant contributions toward ensuring appropriate attention to the interests of the aged have also been secured through normal review of major issues and proposed legislation and regulations related to Federal activities in such areas as the Supplemental Security Income program, Food Stamps, skilled nursing homes and intermediate care facilities, Federal energy policies, adult education, Medicare, Medicaid, adult social services, rehabilitation services, social security and employment policies for older workers, including the new Older American Community Service Employment Program authorized under Title IX of the Older Americans Comprehensive Services Amendments of 1973 (P.L. 93-29).

(a) Interdepartmental Committees

1. Domestic Council Committee on Aging

The Cabinet-level Domestic Council Committee on Aging, established in 1971, is chaired by the Secretary of Health, Education, and Welfare. The Committee

is charged with, among other duties, the responsibility for developing government-wide aging policy. An Interdepartmental Working Group, chaired by the Commissioner on Aging, has been established in order to assist the Cabinet Committee with its work.

During 1974, the Working Group of the Domestic Council Committee established interdepartmental task forces to develop and implement plans for coordinated action programs in the five needs areas of nutrition, research, transportation and energy, I&R, and data collection. To develop and implement these plans, the task forces were convened with representatives from AoA, the Departments of Agriculture, Labor, Housing and Urban Development, Transportation, and Commerce, the Veterans Administration, and ACTION, as well as the Office of Education, Social and Rehabilitation Service, Social Security Administration, and the Public Health Service and the Office of Consumer Affairs within the Department of Health, Education, and Welfare. Other agencies have been involved in coordination activities with AoA on an ad hoc basis. Among these are the General Services Administration, the Office of Economic Opportunity and the Federal Energy Administration.

It is expected that additional task forces will be convened in response to areas of need for interagency collaborative efforts as identified in on-going program analysis and State and Area Agency experiences.

Task Force on Nutrition - The Task Force on Nutrition has sought to identify and plan for ways in which existing Federal resources can be pooled to (1) increase the number of meals provided to older persons through Federal sources other than Title VII of the Older Americans Act, and (2) provide necessary supportive services to the older persons participating in nutrition programs.

Collaborative agreements in support of these objectives have been completed with HUD, DOT, OE, ACTION, the Department of Agriculture and the Veterans Administration.

Task Force on Research - The Task Force on Research in Aging has been engaged in a joint effort to develop ways of effectively coordinating Federal research and related activities which concern the older population. As a first step in that direction, member agencies of the Task Force were requested to consider a number of proposed research question areas in terms of their relevance to the research program, interests, and resources of the respective agencies. These research questions share a common focus in that they bear closely on the development of community service networks.

Once member agencies identified those questions which were consistent with their own research program directions, these interests were shared with the educational community and other interested groups and individuals and identified as an initial step in the development of a coordinated, Federal research program in aging.

In a concerted attempt to avoid duplication of research activities members of the Task Force have agreed to support a comprehensive inventory of research in the field of aging. A joint request for proposal is now being issued for a contractor to undertake this task.

Task Force on Transportation and Energy-During 1974, this Task Force initiated activity in accord with its responsibilities to:

(1) develop an action plan to implement the Presidential directive that all Federal grants which provide services for older persons also insure that the transportation needed to take advantage of these services is available.

(2) review the steps that have been taken to deal with the impact of the energy shortage on essential transportation for older persons, to assess the impact of the shortage on the availability and accessibility of transportation services for older persons, and to recommend action programs which help the Federal Government to better meet the transportation needs of older persons.

(3) develop a series of action programs designed to link existing resources in the area of transportation to the needs of older persons.

A direct result of its activities to date involves a study jointly undertaken by AoA, the Federal Energy Administration, and ACTION to identify and plan for ameliorating the effects of the fuel shortage on volunteer participation in aging programs.

The Task Force on Transportation and Energy has also had particular concern with the conservation of home heating energy and has developed, signed and distributed a joint working agreement in this area. The objectives of the agreement are:

1. To cooperate in the utilization of existing public resources to assist older persons in the insulation and winterization of their homes.

2. To take strong advocacy roles in an effort to respond to the ongoing and emergency energy-related needs of older persons.

3. To provide to older persons clear and accurate information regarding fuel allocation and energy conservation.

Task Force on Information and Referral - AoA has enlisted the support of fifteen Federal agencies to work in concert towards the objective of making I&R activities at the State and local levels more responsive to the needs of older persons. These Federal agencies have also agreed to monitor and evaluate their progress toward this objective.

Other inter-agency activities in the area of I&R are included in the discussion of the National Clearinghouse on Aging, below

Task Force on Data Collection - Work in preparation for the establishment of a Federal Statistical Task Force on the Elderly within the Interdepartmental Working Group on Aging has begun. This task force is scheduled and will have as one of its goals an inventory of all Federal statistical data relating to the older population.

(2) Federal Regional Councils

Each Federal Regional Council (FRC) has established a committee on aging in order to accelerate the development of comprehensive and coordinated programs for the delivery of services to older persons at the community level. These committees have sought to coordinate planning and program activities at the Regional Office level and to respond constructively to State and local program coordination problems within each Region.

The committees on aging generally involve representatives of the various departments and agencies with programs directly or indirectly involved in serving older persons. Some of the committees also include national voluntary agencies with Regional offices such as the American Red Cross. One or two also include the directors of the State Agencies on Aging in either the full committee or in special subcommittees.

Examples of objectives which the Regions are focusing on include the following: (a) development of a retirement planning program for all Federal employees; (b) with support from the Law Enforcement Assistance Agency, reduction of the incidence of crime against the elderly; (c) implementation of the CETA program; (d) an extensive resource directory of Federal resources available to older people; and (e) concentration of Federal assistance in selected sites within the Region where services to the elderly are deficient.

Several regional committees are also using the FRC mechanism to increase Federal agency cooperation with State and area agency programs and in the implementation of the joint working agreements between AoA and other Federal agencies and departments.

(3) Federal Executive Boards

In order to foster Federal-wide involvement in the development of information and referral sources available to all older persons, the Federal Executive Boards (FEB) have identified the development and improvement of such sources as a priority assignment. Accordingly, in each of 25 major metropolitan areas of the country, there is a Federal Executive Board, comprised of the highest ranking officials of each Federal agency in the area, assisting State and Area Agencies on Aging to carry out their I&R responsibilities. FEB involvement has grown out of earlier cooperative activities undertaken among AoA, the Office of Consumer Affairs, and the Office of Management and Budget.

Several FEB task forces have produced or up-dated community directories of services to older persons. Others have begun an effort to coordinate information and referral services. Several are instituting training programs for employees in the FEB member agencies to improve the handling of problems of older persons who may ask the agencies for assistance. Some FEB task forces have instituted community-wide publicity campaigns to encourage older persons to utilize the information and referral services.

b. Other Interdepartmental Coordination

In addition to the multilateral cooperative activities pursued through the Interdepartmental Working Group, during 1974 AoA built upon existing bilateral agreements and cooperative arrangements with other Departments and agencies.

Department of Transportation - DOT and AoA effected a joint working agreement in June which pledged mutual cooperation and coordination in actions designed to achieve increased mobility of older persons by improving their access to public and specialized transportation systems in urban areas. The agreement took note of the fact that DOT set aside $20 million in FY'75 funds from the Capital Assistance Program to implement Section 16(b)(2) of the Urban Mass Transportation Act of 1964, which provides for capital grants and loans to private, nonprofit corporations and associations for transportation of the elderly and handicapped. Title III, Title VII, and other sources, including general revenue sharing funds, are available for support of operating costs for aging transportation projects.

Department of Housing and Urban Development - HUD and AoA have jointly supported a program within the National Center for Housing Management to develop a short-term training program and appropriate materials for managers of housing for the elderly. Also to be involved in this program are trainers from a variety of organizations specializing in housing management. These individuals will then be expected to develop additional training under the sponsorship of their respective organizations, thereby establishing a national delivery capability for the program.

Efforts were also continued by AoA, HUD, and the Law Enforcement Assistance Administration, in regard to security for the elderly in housing projects. This

topic was also chosen as one of the priorities of the Region III, Mid-Atlantic Federal Regional Council Human Resources Committee's Task Force on Problems of the Elderly.

Early in 1975, AoA and HUD will transmit a joint issuance to their respective counterparts at the State and local levels on the Community Development Program under Title I of the Housing and Community Development Act of 1974. The joint issuance will include a description of the Community Development Program and accompanying guidance to State and Area Agencies on Aging on ways in which Community Develoment can be most effective for older persons, with special emphasis on how these funds can be used for the development of senior centers.

Department of Commerce - An interagency agreement was made with the Bureau of the Census for the Census Use Study group to develop their social statistics system for use by State and Area Agencies on Aging.

Current plans call for the completion of a prototype State system in 1975. A manual and instructions for duplication in other States will be completed sometime in 1976.

ACTION - AoA and ACTION developed joint program objectives during FY'74, under which maximum coordination and mutual support between the two programs was pledged. The ACTION objective included the designation of at least one ACTION program designed to provide volunteer opportunities for older persons in each planning and service area for which an agency is designated and an area plan is approved. In addition AoA and ACTION agreed to cooperate in the placement of volunteers in nutrition projects supported under Title VII. Under the terms of the joint objective, State Agencies on Aging were also to provide for maximum utilization of senior volunteers and to support and enhance the objectives of the senior volunteer programs.

Based upon findings of an assessment of activities conducted under the FY'74 joint program collaboration, new FY'75 joint objectives have been developed and an agreement signed. The new agreement expands the scope of the FY'74 joint objectives, with greater emphasis placed on joint activities at the State and local levels.

A Joint Announcement of Collaboration Between the Office of Human Development (Office of Child Development and the Administration on Aging) and ACTION/ National Older Americans Volunteer Programs was signed in August 1974. The Joint Announcement was distributed to OCD Head Start grantees and delegate agencies, State Agencies on Aging, and Foster Grandparent Program Sponsors and/or Retired Senior Volunteer Program Sponsors. The agreement is designed to promote expanded involvement of older volunteers in the Head Start program. Site visits were made to 5 exemplary Head Start/ RSVP programs, after which work began on the preparation of policy and guidance materials for use in developing programs so that additional older volunteers will have opportunities to serve in Head Start programs. These policy guidance materials will be distributed to local programs for their use in working out collaborative efforts at the local level.

Federal Energy Administration - AoA has attempted to ensure that the special problems of older people are granted appropriate attention in all activities of the Federal Energy Administration (FEA) and its predecessor agency, the Federal Energy Office. In addition to reviewing and commenting upon virtually all energy and fuel allocation regulations and plans, AoA, with FEA, and ACTION, initiated a study of aging programs to determine and plan for ameliorating the effects of gasoline shortages on volunteer participation.

The Federal Energy Administration is participating in the Domestic Council Committee on Aging Task Force on Transportation and Energy. Along with other members of the Task Force, the FEA signed an agreement on energy conserva-

tion. The Administration on Aging also participates in the Federal Energy Administration's Consumer Affair Office's Task Force on Energy and Low Income Persons. AoA also reviewed and commented upon two FEA reports on the impact of the Energy Crisis.

Department of Agriculture - AoA and the Department of Agriculture developed an agreement whereby the Department of Agriculture will promptly certify nutrition projects as eligible to accept food stamps toward the purchase of congregate meals in Title VII Nutrition for the Elderly meal sites.

In addition, AoA worked with USDA in the development of regulations to implement Section 707(d), added to the Older Americans Act by the 1974 amendments, which directs USDA to donate surplus commodities to Title VII at a level of not less than 10 cents per meal. These regulations were published in the fall of 1974, and AoA has worked with USDA since then in the development of guidelines for this provision, and in briefing Regional and State staffs on the operations of the commodity program.

Department of Labor - The Administration on Aging has worked closely with the Department of Labor in its development of regulations for implementation and operation of the Comprehensive Employment and Training Act of 1973 (CETA) and for the Older American Community Service Employment Program which was authorized by Title IX of the Older Americans Comprehensive Services Amendments of 1973. The State and Area Agencies on Aging have also been encouraged to take an active role in the implementation of these programs. Technical assistance material has been developed and transmitted to the State and Area Agencies on Aging on the possible actions that can be taken to ensure that the employment-related activities of the Department of Labor and the State and Area Agencies on Aging are coordinated, and that older persons' needs are considered in the development by manpower prime sponsors of comprehensive manpower plans.

Also, information has been provided on the availability of funds for the Emergency Job Program under the Comprehensive Employment and Training Act, and State and Area Agencies on Aging have been urged to work with manpower prime sponsors to ensure that older persons are included among the persons hired under the program.

In addition, the Department of Labor under an agreement with AoA is currently working on a study to enable the Administration on Aging to carry out its responsibility for appraising existing and future personnel needs in the field of aging. Details of this study are presented in the discussion of training, below.

Civil Service Commission - To assure that State Agencies are engaged in meaningful affirmative action activities, AoA and the CSC agreed to make joint visits to State Agencies on Aging for the purpose of assessing State Agency progress. A written agreement to this effect was finalized and transmitted to the field in November.

c. Intradepartmental Coordination

The Administration on Aging has been intensively involved in the development of a series of formal agreements with various agencies within the Department of Health, Education, and Welfare, especially, SRS, PHS, and SSA. These efforts are designed to improve coordination of State and community activities in the areas of information and referral, adult social services, rehabilitation services, community health and mental health services, and comprehensive health planning. Building upon cooperative arrangements pursued during 1974 these formal agreements will reflect AoA's commitment to identify and plan for ways in which Departmental resources can be brought to effectively focus upon the needs and interests of older persons.

Social Security Administration - AoA has continued to work with SSA on the establishment of Information and Referral Services for older people and on the dissemination of information concerning the Supplemental Security Income Program. A comprehensive discussion of I&R activities is presented hereinafter in the discussion of the National Clearinghouse on Aging. AoA has reviewed and commented on virtually all regulations pertaining to the SSI program and in collaboration with SSA, developed and implemented a special project called "SSI Alert" to inform potentially eligible older people about the SSI benefits and options. "SSI Alert" is discussed hereinafter under "Special Projects."

Public Health Service - AoA has been working to update a joint agreement with the PHS under which joint efforts have been focused on cooperative funding of research and demonstration grants, health technical assistance to areawide model projects formerly funded by AoA, planning for long-term care and alternatives to institutionalization, and development of objectives for joint action in health planning.

AoA has also consulted with PHS components, namely the Health Services Administration, Health Resources Administration, and the Alcoholism, Drug Abuse, and Mental Health Administration, relative to the co-sponsorship of selected evaluation projects.

A second joint working agreement has been signed and distributed by the Administration on Aging and the Public Health Service which has as its objective the improved delivery of coordinated health and social services. The agreement is designed to bring about greater coordination between the resources available under the Public Health Service Act and the resources available under Titles III and VII of the Older Americans Act, through joint planning, programming and implementation at the Federal, State and local levels. Specific appropriate activities for coordinated action are noted in the agreement.

AoA has also worked with PHS components and the HEW Office for the Handicapped, formerly the Office of Mental Retardation Coordination, to identify problems of mentally retarded patients in nursing homes. AoA and PHS staff also worked with the Division on Aging of the National Association of State Mental Health Directors to try to effect cooperation with State Agencies on Aging.

Office of Nursing Home Affairs, PHS - During 1974 AoA was assigned additional responsibilities in the area of long-term care, and met regularly with staff of the Office of Nursing Home Affairs to coordinate long-term care-related activities, especially in the matter of improving the quality of institutional care. In these activities, AoA has served as a member of an Interagency Advisory Group, whose other members include respresentatives from the Office of the Assistant Secretary for Health, the Office of Nursing Home Affairs, the Social Security Administration, the Social and Rehabilitation Service, the Public Health Service, and the Office of Fire Safety Engineers.

In July of 1974 seven Nursing Home Ombudsman Demonstration Projects were formally transferred from PHS to AoA. Accordingly, to meet this and other new responsibilities related to nursing home concerns, AoA has recently added a Nursing Home Interests unit to its staff. The functions of the Nursing Home Interests Staff are discussed in the Introduction, above.

Office of Education - AoA has cooperated with the OE Bureau of Libraries and Learning Resources on a demonstration project utilizing libraries as information and referral centers. In cooperation with the Bureau of Adult, Vocational and Technical Education, AoA has also fostered the cooperation of State Supervisors of Home Economics Education as a resource in the nutrition education program, authorized by Title VII of the Older Americans Act.

An agreement signed in January 1975 between the Commissioner on Aging and the Commissioner of Education encourages the expanded use of public school facilities for serving meals to older people. Included in this agreement is provision for a variety of educational, recreational, cultural and other community services and volunteer opportunities for older people.

AoA has also worked with the Bureau of Adult Education to assure that the educational needs of older adults are more adequately considered in special projects funded under the Adult Education Act.

Social and Rehabilitation Service- AoA and SRS have agreed to co-sponsor selected program evaluation studies directed at assessing long-term care alternatives and the development of non-vocational rehabilitation goals for older people.

Agreements have been developed with SRS's Community Services Administration (CSA), Medical Services Administration (MSA), and Rehabilitation Services Administration (RSA).

The agreement with CSA, which is about to be signed, focuses on bringing about maximum possible coordination between the resources available under the Social Security Act and the programs under Title III and Title VII of the Older Americans Act, to provide social services to older persons.

An agreement with MSA, which has been signed and transmitted to the field has as its objective the improved delivery of coordinated health and social services for older persons. The agreement is designed to bring about greater coordination of resources available under the Medical Assistance Program and Title III and Title VII of the Older Americans Act.

An agreement with RSA has been signed by AoA and is currently under final review by the Commissioner of RSA. This agreement establishes a joint working relationship to improve delivery of coordinated health and social services for impaired older persons. The agreement is intended to provide a framework within which to structure joint efforts on consultation and sharing of expertise, planning and implementation of coordinated service delivery programs, and recommendations for future program directions.

4. RESEARCH AND DEMONSTRATIONS

a. Research and Demonstration

The Administration on Aging's research and demonstration program supports projects which add to existing knowledge in a variety of areas which are critical to the development and improvement of aging programs. The primary source of funding for R&D projects in aging is Title IV Part B of the Older Americans Act, as amended by the Older Americans Comprehensive Services Amendments of 1973.

(1) Projects Supported by FY '74 Funds

Under the fiscal year 1974 appropriation of $7 million, 25 new and 94 continuing projects received financial assistance. The new projects were developed in response to a carefully planned research and development strategy which focused on directing research toward knowledge critical to effective conduct of new programs mandated by Titles II, III and VII of the Older Americans Act, as amended by the 1973 Amendments. The new projects described below are primarily directed at generating knowledge critical to effective management and coordination of the comprehensive service networks required since 1973 by Title III of the Older Americans Act.

Continuation projects are those which were initiated prior to July, 1973 and received additional support with FY '74 funds appropriated under Title IV, Part B. These complemented the new emphasis on planning and coordination by continuing the search for applicable knowledge and experience on approaches and services designed to enhance potential for satisfying independent living and reducing the need for institutionalization among the elderly.

New Awards

The following summary of the new start research projects is organized under the five goal headings of the 1974 Research and Development document.

Goal I: Coordination

To anticipate problems in and seek practical approaches to facilitating coordination of planning and delivery of community services for the elderly by State and Area Agencies on Aging funded under Title III of the Older Americans Act of 1965, as amended.

As goal 1 suggests, the main thrust of AoA planning and programming is the development, primarily through the efforts of State and Area Agencies on Aging, of comprehensive and coordinated service systems for older persons. A comparable level of priority within AoA's research program was given to the analysis of the coordination process, the factors which tend to promote or, in other instances, impede effective service coordination.

Four new project grants bear directly on these research objectives, as indicated:

- Two (2) institutions, Yale University School of Medicine and Portland (Oregon) State University, received awards to develop conflict resolutior models which will be compared and tested against actual community settings for planning and service networks.

- The University of California at Berkeley is investigating staff, organizational, and community characteristics of Model City programs for evidence of factors which correlate with successful (or unsuccessful) coordination of services.

- The School of Social Services Administration, University of Chicago, has underway an analysis of conflicting government regulations, policies and guidelines related to aging, leading toward suggested methods for resolving jurisdictional conflicts and untangling legal snarls by either discretionary administrative action or model legislation.

The Title III program also places considerable emphasis at both the State and area levels on making information and referral (I&R) services accessible to older persons and on integrating these I&R sources within a comprehensive, coordinated service system. The following four research contracts have been undertaken with fiscal year 1974 funding to provide a firmer knowledge base for the future development of I&R service systems:

- Applied Management Sciences (Silver Spring, Md.) has been awarded two contracts. The first assesses the organizational structure and interaction of information and referral service programs. The second compares the relative benefits of age-segregated versus age-integrated I&R systems, from the viewpoint of service recipients and providers.

- Cooper and Co., located in Stamford, Connecticut, is developing a reference manual of cost-effectiveness models of information and referral for potential use by State and Area Agencies on Aging.

The Health-Welfare-Recreation-Planning Council in Norfolk, Virginia, has a contract to describe the operation and document the experience of an automated community services information system functioning within the Norfolk and Tidewater, Virginia area.

Goal II: Financial Support

To ascertain the feasibility of, and practical approaches to, assuring that Federal financial resources earmarked or available for the provision of services to older persons under diverse federally-supported programs can be so interrelated as to be directly supportive of the coordination efforts of State and Area Agencies on Aging.

A grant to the Andrus Gerontology Center, University of Southern California, will pursue important dimensions of this subject, and result in two research products:

- A report identifying and analyzing funding regulations, program requirements, and management procedures which impede the pooling of resources on behalf of the elderly.
- A text or manual to assist State and Area Agencies on Aging in dealing with Federal, State, and local regulations, requirements, and procedures for combining available resources.

Goal III: Needs of Low-Income and Minority Elderly

To assure that the development of comprehensive and coordinated service systems for older people address the particular needs of the low-income and minority elderly, the priority target groups of the Title III program.

AoA planning places priority emphasis on encouraging the development and provision of services needed by those elderly least able to influence such development, i.e., the low-income and minority elderly. Identifying these target populations is crucial to effective planning and guidance of the Title III program to bring about measurable and beneficial impact on the status of low-income and minority older persons.

The following five (5) grants were made to conduct research addressed to these target populations:

- The University of Illinois at Chicago Circle will conduct a national survey to provide detailed information on the needs of older people, particularly as these relate to social integration, community services and health and specialized housing.
- The Rand Corporation, Santa Monica, California, will review the literature and analyze census data to identify the status of Black, Puerto Rican, Chicano, Native Americans, and Asian elderly compared to the aged in general.
- The Institute for Research on Poverty, University of Wisconsin, will define "adequate income level" for categoric groups of elderly, and describe multiple factors, besides lack of income, which contribute to poverty in old age.
- The University of Southern California at San Diego will identify special characteristics of different aged minority groups which call for special types and methods of service delivery.

- Case Western Reserve University, Cleveland, Ohio, will determine "if" and "to what extent" certain economic and service incentives can induce and equip family units to provide home care for elderly members.

Goal IV: Needs and Market Demands

To provide a sound knowledge of the characteristics, needs, problems, and generals expectations of older persons, that will permit the formulation of policies, and programs that will more effectively strive toward the national objectives for older Americans Specified in Title I of the Older Americans Act of 1965 as amended.

Under this goal, AoA supports research of a more fundamental, long-range nature which is especially suited to AoA's responsibility as the Federal focal point for aging matters.

Five projects of this nature were funded:

- Catholic University of America, Washington, D.C., has been awarded a grant to develop models depicting decision-making patterns of older persons in their use of available resources and show the effects of ecological, psychological, and biological factors on these patterns of decision making.

- A contract to Lawrence Johnson and Associates of Washington, D.C., will provide information on the service consumption patterns and priorities of the aging through a literature search and sample survey.

- A grant to the Wilmington Housing Authority, Delaware will support a literature search of current knowledge about causes and effects of social isolation among the elderly. An analysis of community programs focused on combating social isolation will be undertaken.

- A grant to the International Center for Social Gerontology, Washington, D.C., will provide a comprehensive literature review on congregate housing for the elderly, placing special emphasis on relevant European experience in this field. The grant will systematically analyze environmental, economic, cultural and other factors that favor success of such programs, with implications for legislative and administrative action concerning congregate housing programs in the United States.

- Grant research by the Center of Demographic Studies, Duke University, Durham, N.C., will indicate what combinations of factors cause older persons to adopt independent, congregate, or institutional patterns of living arrangement.

Goal V: Development, Organization, and Delivery of Services

To ensure that the coordinated and comprehensive services developed in whole or in part under the aegis of the Older Americans Act are structured and delivered in such manner as to maximize the utilization of existing resources, reflect the needs of the recipients, and recognize special problems of sub-populations of older persons.

Four projects were funded under this goal, as follows:

- The California Office on Aging has a grant to identify the characteristic problems and needs of rural older persons, and to assess the scope and effectiveness of typical rural service systems.

- The Virginia Polytechnic Institute and State University has a grant to develop economic models of rural service delivery systems, focusing on communi-

cations and transportation cost elements.

- The School of Social Service Administration, University of Chicago, has initiated research on a series of models that show the effects on older persons of a wide range of service delivery methods.

- The Human Resources Corporation, San Francisco, California, has a contract for research in the area of advocacy in the field of aging, on the part of both organizations and individuals.

Continuation Projects

The continuation projects largely focus on better ways to help the vulnerable elderly return to or remain in their own homes or other appropriate settings. A number of these projects are described below in order to illustrate the wide variety of investigations and knowledge being undertaken on behalf of older persons. A number of these projects receive support from other Federal agencies, in addition to the Title IV funds provided by AoA.

- Building on substantial research in progress, the Office of Elder Affairs in Boston proceeded with a demonstration of community-based home care programs of coordinated health, social and other supportive services.

- A program sponsored by the Chinatown-North Beach Health Care Planning and Development Corporation in San Francisco is directed at three ethnic minority groups--Chinese, Filipino and Italian.

- The Levindale Hebrew Geriatric Center and Hospital in Baltimore is exploring potential changes in Medicare-Medicaid legislation which underwrites health care predominantly within an institutional setting.

- The Burke Rehabilitation Center in White Plains, New York, has a project focused on day care services within the context of total community services linked to an information and referral system.

- Montefiore Hospital in New York City is evaluating day care services with support from these same sources.

- The Colorado Department of Institutions, Denver, is testing the feasibility of specialized boarding homes for elderly persons who have had or continue to have mental problems.

- The Family Service Association of America is attempting to strengthen the quality and expand the scope of programs for the aging in local family services agencies, with the overriding objective of enhancing programs which enable the elderly to remain in their own homes.

- A manual for training homemakers in home care for the elderly has been developed by the National Council for Homemaker Services.

- National Center for Voluntary Action has been developing program guides for voluntary organizations to use in establishing home service programs for the elderly.

- The National Interfaith Coalition on Aging, Athens, Georgia, examined programs for the aging and information systems about services for the elderly, with the goal of improving coordination of public and private efforts for the older adult population.

- The potential for translating electronic and technological advances into care for the elderly is being examined by the Illinois Institute of Technology.

- O'Brien Communications, Inc. Cambridge, Massachusetts, is investigating the potential of cable TV in an information and referral system.

- Interstudy of Minneapolis continued a research project to develop a model for Statewide networks of information and referral centers and a series of manuals designed to guide communities in establishing and operating such centers.

- The Wisconsin Health and Social Service Department tested the above (Interstudy) model in 13 sites in rural and urban centers.

- The Human Resources Department of the State of Georgia is testing a Statewide "Tie-Line" information and referral project which integrates several specialized information components such as consumer information and drug and alcohol information.

- The Massachusetts Department of Elder Affairs is assessing variables associated with a Nursing Home Ombudsman program to improve the quality of care received by patients within Nursing Homes.

- Montefiore Hospital in New York City has evaluated the effectiveness of brief psychotherapy to the bereaved aged.

- The New York State Department of Mental Hygiene has been developing refined measures for the detection of psychopathological conditions in the elderly and identifying implications for treatment.

- The University of Chicago has developed an instrument for measuring personality characteristics in middle-aged and older people.

- The Montana United Indian Association is studying the nature, type and extent of problems and of needs common to elderly urban Indians.

- The University of Pennsylvania is assessing the impact on elderly people of the 1972 flood damage in Wilkes-Barre and the responsiveness of service agencies to the crisis.

- The Oregon State Legislative Interim Committee on the Aging developed a legislative strategy to improve legislative response to the service needs of the elderly as identified by the White House Conference on Aging.

- The University of Southern California Gerontology Center has organized, evaluated, and analyzed research data, concepts, theories and issues on the biological, psychological and social aspects of aging for publication in three Handbooks in Gerontology.

- The Gerontological Society is developing state-of-the-art papers on key social policy needs, possible alternative solutions and the kinds of research, development and information that would be useful in making policy decisions.

- The Stanford Research Institute is exploring national policies affecting the elderly and predictions for the future, based on alternative policies.

(2) Projects to be Supported by FY'75 Funds

Of the FY'74 projects, approximately 30 will be continued in FY'75. Of the $7 million FY '75 funding, AoA plans to support approximately 50 new research and demonstrations projects:

FY '75 New Starts will respond to a research strategy designed to support AoA program goals. AoA will fund research and demonstrations projects which will:

- Assist in identifying and understanding those processes of aging uniquely associated with or inherent in the make up of the elderly. Such knowledge will permit the development and implementation of programs responsive to the capabilities and functionings of the elderly.

- Provide knowledge of characteristics, attitudes, behaviors and distributions of older persons. Such knowledge will permit formulation of policies and programs which will facilitate the achievement of equal opportunity and access to the objectives specified in Title I of the Older Americans Act of 1965, as amended.

- Provide knowledge and understandings of social, economic, and environmental forces which impinge on the ability of the elderly to secure and maintain "freedom, independence and free exercise of individual initiative in planning and managing their own lives."

- Provide knowledge descriptive of intervention mechanisms and the responses of the elderly to those interventions. Such knowledge will provide the understandings necessary for the development, organization and delivery of service, as well as the coordination of delivery systems, as supported under Titles III and VII of the Older Americans Act of 1965, as amended.

Dissertation Fellowship Program: AoA will implement a dissertation research program which will seek to encourage research in the field of social gerontology and related areas. The program's goal is to gain new insights into the needs, circumstances, resources, expectations, and roles of the nation's older population, including the following research activities:

- Identifying and assessing patterns, conditions, and new approaches which contribute to a wholesome and meaningful life for older people.

- Developing and evaluating new approaches, methods, and techniques for improving coordination of community services for older persons.

- Collecting and disseminating information concerning research findings and other materials developed in connection with activities under the Older Americans Act.

b. Model Projects of National Scope

The Model Projects program provides support for projects designed to develop, test and display better ways to promote the well-being of older persons by increasing both the scope and quality of services. Authority for this program is provided under Section 308 as added to the Older Americans Act by the 1973 Amendments. The program is administered by AoA's Division of Research Applications and Demonstrations.

In making awards, special consideration is given to applications which: (1) assist in meeting the special housing needs of older persons; (2) provide continuing education to older persons; (3) provide pre-retirement education, information and related services to the elderly; and (4) provide services to assist in meeting the particular needs of the physically and mentally impaired older person including special transportation and escort services, homemaker, home health and shopping services and other services designed to assist such individuals in leading more independent lives. It is anticipated that FY'75 funds will also support some projects designed to elicit effective ways to help older persons to better cope with the economic pressures of recession and inflation.

In FY'75 approximately forty model projects will receive support. Of these, most will be funded in the special emphasis areas noted above. Examples of previously funded projects follow.

In the area of housing, a project in North Carolina is directed at increasing the number of older persons receiving housing assistance through : 1) advising older persons on the rental housing market; 2) making referrals to subsidized housing programs; 3) counseling homeowners on housing rehabilitiation and identifying and applying resources for housing repairs; and 4) counseling older persons who wish to buy housing and assisting in applications for mortgage programs.

In the field of education, six Minnesota educational institutions have formed a consortium and are developing and operating a replicable model of a State-wide network designed to make continuous, lifelong learning of high quality available to older persons and those serving them.

In the area of pre-retirement planning and preparation, the Duke University Medical Center, North Carolina, is developing a planning-counseling model and a critique of pre-retirement training models. Included is a study of the effects of pre-retirement training on different socio-economic groups.

In assisting the physically and mentally impaired older person, the Papago Indian Tribe of Arizona, the Inter-Tribal Council of Nevada and the Gila River Indian Community of Arizona, are using Indian homemaker health aides and outreach aides to demonstrate ways to improve the health, living conditions and social involvement of aged reservation residents. In addition, the New York City Office for the Aging is demonstrating particular approaches to better meeting the needs of mentally frail older persons.

In information and referral, the New Life Institute, New York, is establishing a national ciearinghouse for private, non-profit community agencies specializing in job placement services for the aging.

In accordance with the Administration on Aging's policy to reduce natural disaster-related problems for older persons, State Agencies on Aging in Alabama, Kentucky, Tennessee and Indiana were granted awards to provide extensive outreach and follow-up services, after recent natural disasters. These activities are discussed later in this report, under "Special Projects."

5. TRAINING

Under the new Title IV, Part A of the Older Americans Act, as amended, AoA is authorized to help meet critical shortages of adequately trained personnel for programs in aging by: (1) developing information on the actual needs for personnel to work in the field of aging, both present and long range; (2) providing a broad range of quality training and retraining opportunities, responsive to changing needs of programs in the field of aging; (3) attracting a greater number of qualified persons into the field of aging; and (4) helping to make personnel training programs more responsive to the need for trained personnel in the field of aging.

The following manpower and training activities were in progress in 1974.

a. Career Education in Aging

Career training programs sponsored by the Administration on Aging were under way at 47 institutions during the 1973-74 school year. These included 34 program which offered interdisciplinary education with specialization in gerontology, and 13 awards which were made to schools of social work to prepare students for

community development to meet the needs of the older population. Approximately 400 students received traineeships from FY'73 funds for education in the 1973-74 academic year (training grants are forward funded).

Since the inception of the program, most of the career training has been offered at the graduate level. In 1974, career support was provided for training at the baccalaureate as well as the masters and doctoral levels. The objectives of this career development program are to prepare practitioners for State and Federal program planning and administration, community development and coordination, management and administration of retirement housing and homes for the aged, senior center direction, teaching and research, and for serving older people through adult education, architectural design, counseling, law library service, recreation, and other relevant fields.

Each career-oriented training program included an intensive practicum of three to nine months. Students and graduates have demonstrated to program agencies the value of personnel who have systematic knowledge of the aging processes and of older people. An evaluation study commissioned by AoA during the 1973-1974 period showed that over 60% of all recipients of AoA traineeship awards prior to September 1972 are currently employed in aging or aging related jobs.

Administration on Aging-supported career training programs have from their inception sought to recruit students from all minority groups. During FY'74, eight programs were in operation at minority institutions or other institutions with programs specifically focused on minority students. Approximately 22% of the students being supported were from minority groups.

For the 1974-75 academic year, educational institutions which supported career training programs in 1973-74 are operating under one year continuation grants from FY 1974 funds. These funds are being used primarily to support existing programs in gerontology, including student support based on need as determined by the university. Approximately 4600 students are enrolled in aging courses and programs at these AoA-supported training institutions; 625 of these students received financial assistance as part of the FY 1974 career training grant awards.

b. Short-Term Training

AoA has supported a number of short-term intensive training programs which have provided skills to several thousand persons recruited from all parts of the country. With the implementation of Titles III and VII a great many newcomers have been attracted to the field of gerontology. Upgrading of competencies has also been required by many persons who were already in the field of aging prior to the passage of the 1973 Amendments to the Older Americans Act but were given new responsibilities under that legislation. During 1974 support for short-term training was expanded to meet these needs. Examples of short-term training activites include the following:

- An award was made to Syracuse University to develop six seminars to train, by the end of FY'75, 170 State Agency Executives and key staff in leadership roles and responsibilities that derive from the broad mandate of the Title III legislation.

- In the area of nutrition, grants were awarded for continued support to five programs where nutrition program training was already underway.

  Funds will be used primarily to provide technical assistance to State Agencies on Aging to prepare additional trainers in nutrition by providing updated knowledge about Title VII operations. In addition, Oregon State University will continue to develop, collect and disseminate nutrition materials.

- The Assistance Group, Inc. of Silver Spring, Maryland was awarded a contract to train, by February 1975, approximately 75 State Agency personnel in techniques of providing technical assistance to persons at State and local agencies who are responsible for meeting the Administration on Aging's requirements for Information and Referral programs.

To supplement the short-term training activities undertaken to prepare State and Area Agency personnel and nutrition project staff, additional FY '74 funds were awarded to State Agencies on Aging for training and manpower development activities at State and local levels which are not addressed by the national training efforts, but are necessary for effective implementation of the 1973 Amendments.

Grants were awarded to ten colleges and universities to conduct symposia for faculty members and others who will be offering courses related to the needs of older persons as part of state short-term training programs. The symposia will present current information on training materials and methods, as well as information related to programs under the Older Americans Act. These symposia are expected to complement other Administration on Aging training and manpower development initiatives.

c. Manpower Development

In accordance with Sections 402 and 403 of Part A, Title IV, efforts are being supported to assess present and future manpower needs in the field of aging and to increase the range of professional and vocational skills available to serve older persons.

The Department of Labor, under an agreement with AoA, is currently working on a study to enable the Administration on Aging to carry out its legislative mandate to appraise existing and future personnel needs in the field of aging and to report on the nation's capability to meet those needs. The DOL study is divided into two phases as follows: 1) An analysis of current and projected manpower needs, by occupation, in nursing homes with an analysis of future supply-demand conditions for several professional occupations important to the field of aging; and 2) An analysis of the key questions AoA must consider in the development of a long range strategy to carry out its manpower-related responsibilities.

Examples of other grants made by AoA with FY'74 funds pursuant to its responsibilities in the areas of manpower development and training include the following:

- Two projects which are designed to attract artists to the field of aging in order to make artistic activities more available to older persons.

- A project which is designed to serve as a national model for programs which have as their objective recruitment, training and job placement for older persons in the area of health-related services for the aging.

- A project to upgrade the training of American Indian paraprofessionals working with the elderly American Indians.

- A program designed to train operators of family care homes for older persons in Kentucky, where such homes have recently come under the provisions of State-wide licensing requirements.

- As of December, 1974 funding of the National Center for Housing Management has resulted in the training of 241 managers of housing for older persons and 7 trainers in this field. By the end of FY'75 it is anticipated that 1000 housing managers and 20-30 trainers will have been trained.

d. Conferences

A number of grants were made to assist in training persons who are employed or preparing for employment in the field of aging through seminars, conferences, symposia, and workshops to facilitate exchange of information and to stimulate new approaches with respect to activities related to the Older Americans Act. Support was provided for the following activities:

The Sixth Biennial International Senior Citizens Congress, International Senior Citizens Association, Inc.

National Conference on Reducing Crimes Against the Elderly, American University, Washington, D.C.

Conference of Legal Services Projects, National Senior Citizens Law Center, Los Angeles.

National Conference on the Spanish Speaking Elderly, National Chicano Planning Council, Inc., San Jose, California.

Gerontological Conference on Mental Retardation, University of Michigan.

Meetings with the Institute for Operational Research, Tavistock Institute, London-Duke University Center for the Study of Aging and Human Development.

International Congress of Gerontology in Israel-Gerontological Society.

Support for Black Educators Council for Human Services (BECHS)-North Carolina A&T State University, Greensboro, North Carolina.

e. Other Special Projects

During 1974 the American Association of Community and Junior Colleges (AACJC) completed its activities undertaken with AoA funds.

The grant produced two items which have already been distributed by AACJC to all 1100 community colleges, and by AoA to all State and Area Agencies and others on request. The two documents produced were based on a survey of the 1137 community and junior colleges and technical institutes that was undertaken in October, 1972 and updated in March, 1974.

(1) Older Americans and Community Colleges: An Overview -

Provides an inventory of aging programs and services offered by community and junior colleges in the areas of

- manpower training programs - 40 + schools
- retired senior volunteer programs 26 schools
- retirement education programs 140 + schools
- cultural enrichment courses 340 + schools
- free or reduced tuition 160 + schools

(2) Older Americans and Community Colleges: A Guide for Program

Implementation - Provides a great many specific suggestions on what programs and services can be offered and how to go about developing such programs, including an appendix that contains outlines for individual courses eg. Homemaker-Homehealth Aide Course, as well as outlines for developing Associate Degree and Certificate Programs.

The Adult Education Association (AEA) completed a study which was supported by AoA in Fiscal Years 1973 and 1974. The subsequent report, New Learning for Older Americans: An Overview of National Effort, is based on interviews with experts, a literature analysis, and 3500 responses to a questionnaire sent out in January and February, 1974.

The report will be published and distributed by the Adult Education Association. It is expected that the document will generate increased interest in adult learning among the education agencies, the libraries, museums, and Cooperative Extension Service, as well as other community agencies having a potential role in adult learning.

The need for substantive staff development for Administration on Aging personnel is being addressed through the use of S&E funds which were available to AoA in FY '74. A contract was awarded to E.H. White Inc. for the development and delivery of a curriculum for all Central and Regional Office staff in 1975.

6. EVALUATION

The AoA Evaluation Plan for fiscal year 1974 stressed the need for information on the elderly and services to the elderly at the national, regional, State, area, and project levels. It was designed to initiate the conduct of studies related to the overall effectiveness of AoA policies and programs and to their impact on the aging population, rather than to evaluation of individual grantee management performance.

The FY'75 Evaluation Plan stresses the evaluation of the major AoA programs; the Area Planning and Services Program, Nutrition Program for the Elderly, and Information and Referral. Contracts for these evaluations will be let in the fourth quarter of FY'75.

In support of these plans AoA had, by the end of 1974:

(1) Developed a request for proposal for a longitudinal evaluation of the Title VII, national Nutrition Program for the Elderly, based on methodology previously pilot tested by AoA. The evaluation study will attempt to measure the impact of the program in terms of its effect on the health status, nutritional status, isolation, life satisfaction, longevity, and institutionalization of the participants.

(2) Based upon in-house research and information collected by the National Bureau of Standards, AoA has been developing a methodology for the evaluation of the organizational effects of Area Agencies on Aging.

(3) Sent out for comment by selected regional, State and Area Agency personnel the Older Americans Status and Needs Assessment Survey for use by State and Area Agencies. The package will include a utilization manual with ideas for use of the data collected for public relations, legislative relations, planning, evaluation, and coordination and instructions for performing a survey.

(4) Work began, under contract on the second part of the AoA Data Base to collect data on the minority elderly and services for older persons. The first portion of the AoA Data Base contract has already been com-

pleted. This includes statistical data on two of AoA's target groups, the low-income elderly and the impaired, noninstitutionalized elderly, as well as a data organization and Termatrex retrieval system.

During 1975 an AoA contractor will proceed on the development of a thesaurus of terms covering the field of gerontology, by which all data base materials will be indexed. This thesaurus will be of use to all professionals in the field of gerontology. Further information on the Data Base is contained in the discussion of the National Clearinghouse on Aging, below

(5) Funded a project with the Census Use Study Group, Bureau of the Census, to develop a social statistics system for use by State and Area Agencies on Aging. It utilizes existing data from various sources, organizes the data and allows analysis of the information in order to determine the status and needs of the elderly. A prototype system is being developed for Nebraska. Complete instructions will be provided to allow duplication of the prototype system. A report for use by Area Agencies will be distributed sometime in 1975.

Other evaluation studies in progress are listed below.

1. Secondary Data Manual: A manual outlining the possible sources of secondary data, such as census reports, for use in planning by State and Area Agencies was developed and will be distributed shortly.

2. Nutrition Outreach Evaluation: This evaluation is measuring the effectiveness of the nutrition projects in reaching and serving those most in need including the minority, impaired and isolated elderly.

3. Strategy Evaluation for the National Clearinghouse on Aging: This project will produce a strategy for establishing the National Clearinghouse. It will survey potential users and sources of information as a basis of the strategy.

4. R&D Utilization Evaluation: This project is collecting information on highly utilized and poorly utilized R&D projects in an attempt to determine the internal and external variables which have affected the utilization of the results. Both project staffs and potential users are being interviewed.

5. Evaluation and Monitoring Tools for Area Agencies on Aging: Three self-evaluation and monitoring tools have been developed and are being tested by Area Agencies on Aging. The tools deal with the following areas:

   a. self-assessment of basic functions and preparation for the State assessments;

   b. evaluation of existing service providers' capacity; and

   c. evaluation and monitoring of service providers with whom the area agencies have agreements or contracts.

   Each of these tools will be pretested in five Area Agencies on Aging in order to determine its applicability and ease of performance. State Agency and Regional Office staffs will also be trained in their use.

6. State Agency Evaluation: This project is using the structured case study approach to evaluating the effectiveness of State Agencies on Aging in terms of their planning, coordination, evaluation, grant administration, advocacy and technical assistance functions. Fifteen

State Agencies will be studied, and both qualitative and quantitative information will be collected and analyzed. In FY' 77-FY'78 these States will be revisited for follow-up evaluations.

7. Evaluation and Monitoring Tools for the Nutrition Projects: This project will produce several tools which may be used by nutrition project directors including: combined guide for a site assessment and preparation for State assessments, a former participant questionnaire, a home delivered meals assessment guide, a food service contract monitoring tool, and a community food preparation costs comparison tool.

8. Systematic Review of Area Agencies on Aging: This systematic review of Area Agencies on Aging is a collection and analysis of data on the area agencies. Data relevant to agency type, funding level, staff size, planning and service area demographic characteristics, etc. has been collected from Regional Offices and State Agencies on Aging. The data is being organized and analyzed in an attempt to identify the major characteristics of the Area Agencies and, as appropriate, to classify systematically the agencies under general types.

9. Evaluation of Aging Magazine: An in-house evaluation is being conducted to assess Aging, a magazine published by AoA's National Clearinghouse on Aging.

10. Evaluation of Alternatives to Institutional Care (Co-sponsored With SRS): Work is underway to develop a study methodology through the use of sample surveys to determine costs and impact of various forms of long-term care in both community and institutional settings. The methodological approach is being developed as part of the Older Americans Resources and Services (OARS) study at Duke University, N. C. An actual study will probably be funded in FY'76.

7. NATIONAL CLEARINGHOUSE ON AGING

In response to the 1973 Amendments to the Older Americans Act, the Administration on Aging created a National Clearinghouse on Aging as authorized by Title II of the Act. The Clearinghouse is charged with: (a) collecting, analyzing, and disseminating information about older people and their needs; (b) providing information to agencies and organizations with respect to programs for older persons; (c) encouraging the establishment of State and area information centers and referral services; (d) carrying out a program of consumer education for older people; and (e) stimulating other agencies to prepare and disseminate information for the field of aging.

Four distinct but interrelated organizational units comprise this new AoA element Data Analysis and Dissemination, Information and Referral Policy, Public Information, and Public Inquiries and Publications Distribution.

All activities carried out under the Clearinghouse are supported through the regular use of S&E funds available to the Administration on Aging.

AoA needs a wide spectrum of information in order to serve effectively as advocate and program facilitator toward realization of the national goals for older persons, and to meet its own program objectives. The range of information needs includes: general information about the problems and conditions of the elderly necessary to raise the level of awareness, concern, and sensitivity of the public-at-large to the situation of the aged and aging; information intended for older persons to increase their awareness and familiarity with social and health services available for their use; information regarding the results of research in the field of aging for the use of professional practitioners; information on the planning, programming and administration of services for the use of public and private agencies;

comparative statistics and related data on the aged and aging to assist decision-makers at all levels in policy formulation, goal specification and resource allocation.

a. Data Analysis and Dissemination

In 1974 AoA continued to provide a variety of statistical information to planners, program administrators, researchers, and others within governmental agencies at all levels and to personnel of non-Government organizations. In addition, initial steps were taken to expand the existing collection of data and to equip a data library storage and retrieval system.

(1) Development of the Data Base

Contracts were awarded through the use of Evaluation funds to initiate the Data Base. The three awards are cited in the discussion of evaluation, above. An essential component in the development of the National Clearinghouse, the Data Base will contain a store of materials on the characteristics, circumstances and needs of older persons. In 1974 the focus has been on the collection and structuring of data relative to the low-income and the impaired non-institutionalized elderly. However, the collection is now being expanded to cover the entire older population, with emphasis on racial and ethnic minority groups.

A thesaurus of terms with inputs from professionals and practitioners in the field of aging is being developed for use by persons interested in aging. The thesaurus will be linked to the Data Base. Plans for the development of a dissemination system are being implemented in 1975.

(2) Provision of Statistical Data

During 1974, several publications were completed. The Facts and Figures on Older Americans series was augmented by the issuance of -

Number 9. The Older American Indian Population: Geographic Distribution, 1970
Number 10. Cumulative Index to Facts and Figures on Older Americans Number I through Number 9, September, 1974
Number 11. Income and Poverty in 1973.

Two new items were added to the statistical series. These included: No. 28 BLS Retired Couple Budget, (Supplement #4); No. 29 Federal SSI and Federally Administered State Supplementation for January 1974, and OAA in October 1973.

(3) State Data Books

Maintenance of the State Data Books, previously supplied to State Agencies on Aging was continued. New data, supplied from a variety of sources, were used to prepare replacement pages which updated a good deal of the State and county statistical information provided in earlier issuances. Additional resource information, originating from other Federal agencies and from private organizations was provided to the State and Area Agencies on Aging.

(4) Response to Specific Requests

AoA responded to numerous requests for demographic, financial, and other data about the older population. Requests came from public agencies at Federal, State and local levels and from nonprofit and profit-motivated organizations. Data were sought for purposes of research, planning, program administration, and education. Several requests came from the Senate Special Committee on Aging, the House Ways and Means Committee, and other legislative committees.

(5) Inter-Agency Task Force

Preparatory work to the establishment of a Federal Statistical Task Force on the Elderly within the Interdepartmental Working Group on Aging has begun. This task force is scheduled to have its first meeting in early 1975 and will have as one of its goals an inventory of all Federal statistical data relating to the older population.

b. Public Information

(1) Older Americans Month

A total of 75,000 copies of the President's Proclamation were distributed widely early in May, along with a folder entitled "Toward a Declaration of Rights and Obligations of Older Americans." The Proclamation called for a revision of the Senior Citizens Charter which had been developed during the 1961 White House Conference on Aging and which listed rights and obligations of older people. It suggested that groups at the community level reconsider this list and develop a new Declaration that can be proclaimed in 1975 and "become a rallying point for our Nation during the Bicentennial year of 1976." The folder repeated this suggestion and included a copy of the orginal Charter.

During the month, a TV public service announcement on the rights and obligations of older Americans was distributed to commercial television stations and State Agencies on Aging. In States requesting it, the tag line for responses to the spots gave the State agency address. More than 250 television stations responde to a questionnaire card distributed with the spot, indicating that they would give it air time for varying periods, some for as long as a year. Most of the State agencies are offering their spots to cable or public television stations in their States.

(2) TV Series on Aging

A 10-part television series on aging was produced by AoA in association with WRC-TV, Washington, D.C., for showing on NBC-owned stations. The ten 30-minute programs are currently being aired in Washington, D.C., Cleveland, New York City, Los Angeles, and Chicago.

The series examines attitudes toward aging and problems faced by older Americans, and indicates services designed to help older people live more independent and rewarding lives. It is moderated by Bertha S. Adkins, Chairman of the Federal Council on the Aging and features guests from Congress, Federal, State, and local agencies on aging, as well as representatives from national organizations, universities, and non-profit agencies concerned with older people.

(3) State Communications Conference

In November, a pilot communications conference was held in Columbus, Ohio, sponsored by the Administration on Aging, the Ohio Commission on Aging, and the Academy for Contemporary Problems. The purpose of the conference was to stress the need for coordinated planning and action among government and non-government agencies that serve older people and to outline ways to improve communications among these units.

(4) Major Publications

Eight issues of the AoA magazine Aging were published in 1974. In a new departure, Aging published major signed articles on three topics of national interest: legal advocacy for the low-income elderly, operation of the SSI program, and crimes against older persons.

A Spanish translation of To Find the Way to Services in Your Community, entitled Para Encontrar El Camino A Los Servicios en Su Comunidad, was printed and distributed through State Agencies on Aging and on mailing lists of the President's Committee on Opportunities for the Spanish Speaking.

The Guide to Effective Project Operations: The Nutrition Program for the Elderly was also translated into Spanish and distributed to those States requesting it for the use of project personnel.

A booklet called Older Americans are a National Resource and a poster with the same title were printed early in the spring of 1974. The booklet describes the programs of three Federal agencies--the Administration on Aging, ACTION, and the Department of Labor --which provide opportunities for older persons to help their communities.

In addition to fact sheets and press releases, other publications produced during the year included:

Three publications prepared by nutrition research and demonstration projects funded by AoA: Packaging for Home Delivered Meals; A Selected Annotated Bibliography: Nutrition and Aging; and Home Delivered Meals: A Selected Annotated Bibliography.

Older Americans and Community Colleges: An Overview, a directory of community colleges with programs in the field of aging, prepared by the American Association of Community and Junior Colleges as part of a training project funded by AoA.

A number of other publications have been prepared and are now at press, including:

To Find the Way to Opportunities and Services for Older Americans, a revision of the booklet To Find the Way to Services in your Community.

The Older Americans Act of 1965, as Amended Through 1974

Transportation for the Elderly: The State of the Art, the report to Congress on transportation required by Title IV, Section 412(a) of the 1973 Amendments to the Older Americans Act.

I and R Program Configuration: A Guide for Statewide Planning, the report of a study funded by the South Carolina Commission on Aging.

Homes for the Aged: Supervision and Standards, a translation of a German study of homes for the aged in several European countries.

Publication Information Guide for Area Agencies on Aging, a report with suggestions for effective ways of contacting the media, preparing press releases and public service announcements, arranging for public hearings on annual plans, and other related activities.

c. Information and Referral

A new requirement set forth in the Older Americans Comprehensive Services Amendments of 1973 is that State and Area Agencies on Aging provide for all older people to have reasonably convenient access to information and referral services which will help to link them with opportunities, resources, and services that enable them to meet their needs and enhance the meaning of their later years. Assisting State and Area Agencies in launching or improving existing information and referral services has become a major AoA activity.

The primary responsibility for developing information and referral data and policy and procedures is lodged in AoA's National Clearinghouse on Aging which works closely with AoA's Office of State and Community Programs.

(1) Technical Assistance and Guidelines to State and Area Agencies on Aging

Agencies providing information or information and referral (I&R) services have been increasing in recent years. Many State and Area Agencies on Aging took steps during 1974 to extend these services to older people. Simultaneously, the Administration on Aging began to accumulate information about the operation and delivery of information and referral services to share with State and Area Agencies. Several manuals describing procedures for establishing and conducting I&R services were distributed to all State Agencies on Aging.

Regulations established pursuant to the 1973 Amendments to the Older Americans Act require that information and referral services become available to all older people by the end of fiscal year 1975. In order to assist State and Area Agencies in identifying existing services of information and referral and fostering the establishment of such sources where none exist, the Administration on Aging issued a program instruction specifying minimum components of I&R services to be put into place by June 30, 1975, and an information memorandum identifying suggested goals toward which State and Area Agencies on Aging should work in the development of these services.

Research and demonstration projects supported by AoA and other agencies, and operational experience in this area have combined to bring about gradual improvements in the nature and quality of information and referral services. A number of national voluntary organizations have formulated standards and recommended them for adoption by the I&R field. Utilizing this material, AoA in collaboration with regional office, State Agency, and Area Agency personnel, developed a reference guide for the use of State and Area Agencies on Aging which identifies the components of a comprehensive information and referral service.

AoA has also provided for training of selected personnel and additional technical assistance to State and Area Agencies in planning and developing I&R services which meet AoA requirements. Three consecutive four day training sessions were held in Philadelphia, Chicago and San Francisco.

(2) Interagency Cooperation

The Older Americans Act mandate in regard to information and referral services makes it essential that existing I&R resources are utilized maximally. Toward this end, AoA has been involved in concentrated efforts to produce both intradepartmental and interdepartmental cooperation in this program area.

Through an intradepartmental agreement, DHEW's resources for older persons will be coordinated by the establishment and tracking of joint information and referral service objectives among the Administration on Aging, the Social Security Administration, and the Social and Rehabilitation Service.

Similarly, through an interdepartmental agreement AoA has enlisted the support of fifteen Federal agencies to work in concert toward making I&R activities at the State and local levels more responsive to the needs of older people. These Federal agencies have also agreed to monitor and evaluate their progress toward this objective.

In addition, the 25 Federal Executive Boards (FEB's), composed of heads of Federal agencies, took as their major project in FY 1975 the improvement and coordination of I&R services and government information services in the areas they serve. FEB personnel, working closely with State and Area Agencies on

Aging, are expected to have a major impact on the improvement of information and referral services for the 50 plus percent of the older population that resides within the FEB areas.

(3) Grants and Contracts

To obtain information pertinent to the I&R field in general, AoA made a number of contracts and grants during 1974 which will document and assess I&R systems, investigate the cost effectiveness of a sample of I&R services, and compare the effectiveness of I&R's serving older people exclusively with that of I&R's serving people of all ages. Those studies are cited in the discussion in this report of research and demonstrations, above.

d. Public Inquiries and Publications Distribution

During 1974 the Public Inquiries and Publications Distribution unit prepared 1,600 letters in response to a broad range of inquiries concerning needs of older persons in such areas as transportation, social services, housing, health care, senior centers, income security, nutrition, legal services, employment, volunteer opportunities, and consumer protection. A number of inquiries and comments were received concerning the effects on older persons of current economic and energy problems. Many of these inquiries are forwarded by Congressional offices, the White House and Federal Agencies, as well as private organizations, older people, and persons working in the field of aging.

In addition, over 3,000 telephone calls were responded to, and a number of visitors were given assistance and information.

During the year AoA distributed 485,000 copies of publications addressed to older people and to personnel of agencies serving the older population. Many of these go out with letters in response to inquiries; the majority are distributed in response to direct requests from individuals or from organizations for distribution at meetings and conferences. Bulk orders are distributed by the Office of Human Development's Publications Distribution Center. Most of AoA's publications are also sold by the Superintendent of Documents.

8. SPECIAL PROJECTS

a. AoA Role in Disaster Planning

Like other government and private agencies, the Administration on Aging moved quickly to aid elderly victims of tornadoes which made a destructive sweep across eleven States in Regions IV and V on April 3, 1974.

The Administration on Aging Central and Regional Office staffs were immediately ordered to work with State and Area Agencies on Aging in the affected areas. They helped put elderly disaster victims in touch with emergency assistance provided through such groups as the American Red Cross, Salvation Army, and the Federal Disaster Assistance Administration (FDAA).

AoA staff worked with State and area officials to determine the extent of losses suffered by the elderly, the extent of unmet needs, and the resources available to disaster victims. The Area Agencies on Aging followed up with the elderly disaster victims to: 1) inform them of the types of assistance available from disaster relief programs, 2) assure that they were linked up with emergency services, 3) assist them in dealing with the processing of claims, and 4) work with the service providers to inform them of the special needs of the elderly as well as any specific eligibility criteria which might have precluded the participation of persons aged 60 and over in disaster relief programs.

A variety of services were extended to elderly victims. These included medical services funds to replace such lost items as eyeglasses and dentures; meals from AoA's Older Americans Act Title VII nutrition program; use of ACTION - RSVP volunteers; senior aides from a Department of Labor program who assisted in cleanup operations and minor home repairs; relief funds from the Office of Economic Opportunity; and a State optometrist society which provided eyeglasses.

An example of State level response occurred in Indiana where the State Commission on Aging and Aged, with the backing of the Governor, embarked on Project Transition, a follow-up operation to make sure all disaster-related resources were made available to elderly victims.

On the national level, AoA worked closely with the American Association of Retired Persons-National Retired Teachers Association, whose mission was to focus the attention of national voluntary organizations and to stimulate action when necessary to aid the elderly.

Where necessary, AoA made available funds under its Older Americans Act Title III Model Project authority to aid local relief operations.

As a result of close monitoring of the Model Project grants and frequent site visits, the Administration on Aging gained considerable knowledge of the approach State and Area Agencies on Aging should take in meeting the special needs of elderly disaster victims. Utilizing this knowledge, the Administration on Aging began working closely with the Department's Civil Defense Coordinator and the Federal Disaster Assistance Administration regarding these special needs. Subsequently, the pamphlet HEW Disaster Assistance Programs was revised and included information developed by AoA on assistance for older people. In addition, AoA submitted to the Federal Disaster Assistance Administration a set of suggested areas of concern regarding older people.

In November the Federal Disaster Assistance Administration included AoA's set of suggestions in its program guidance for the States and in its own review and evaluation of disaster programs and plans developed under the Disaster Relief Act of 1974. Accordingly, the Administration on Aging instructed the State Agencies on Aging to initiate efforts which will assure that State disaster preparedness plans include provision for older disaster victims. Other AoA activities in regard to disaster assistance for older persons included conferences with the American Red Cross, AoA Regional Offices and State Agencies on Aging.

2. SSI-Alert Outreach Activities

Beginning with a press conference held by the Secretary of the Department of Health, Education and Welfare on November 29, 1973, Phase I of SSI-Alert was launched as a joint effort in which two DHEW agencies, the Social Security Administration and the Administration on Aging, joined with a national consortium of eight voluntary organizations to:

a. Seek to enlist the assistance of all the public media in explaining who is eligible for the Supplemental Security Income Program and how individuals can establish this eligibility;

b. Utilize personnel in the field offices of certain departments and agencies of the Federal Government to help identify persons who might be eligible for the program;

c. Provide a volunteer-supported local procedure for receiving, listing and transmitting the names and addresses of potential SSI eligibles to the Social Security district offices;

d. Provide a focal point for the recruitment, training and utilization of volunteers to seek and explain to individuals the nature of the program and the steps to be taken to determine eligibility; and

e. Facilitate the determination of eligibility for those potential eligibles who desire to become a part of the new program.

It was expected that as a result of Project SSI-Alert, many thousands of older disabled and blind persons eligible to participate in the benefits of the SSI program would, in fact, receive these benefits. SSI-Alert outreach was especially addressed to those hard-to-reach persons, including minority older persons, who are often not reached by assistance programs. Project SSI-Alert was designed to effectively assure that the goals established by the Congress in enacting the Supplemental Security Income program would be met with regard to potentially eligible older persons, who could be reached by volunteers.

At the request of the Administration on Aging, the American National Red Cross facilitated the participation of local Red Cross chapters to become the lead agencies in working with the local consortia in the selection of a project director, in the recruitment and training of volunteers and in the development and conduct of the program. Local Red Cross chapters became the lead agencies in 412 out of the 631 Social Security district office areas. Area Agencies on Aging became the lead agencies in 49 districts, Community Action Agencies in 58 districts, and other community organizations in 112 districts.

State agencies on aging were designated as the State-wide lead agency for their respective States and were given FY 1973 and FY 1974 Model Project grants for SSI-Alert implementation. The State agencies were:

a. Authorized to recruit a staff person to provide over-all leadership,

b. Authorized to approve budgets submitted by the lead agencies within the Social Security districts in their States up to the total amount set aside for each State, and

c. Charged with the responsibility of selecting a lead agency for the Social Security districts within their States where the local Red Cross chapter decided not to participate

During the approximately seven months that SSI-Alert Phase I was in operation tens of thousands of volunteers have participated with the largest number, namely, 55,775, being recorded in the first week of April.

Many methods were employed by the consortia and the lead agencies to call the Supplemental Security Income program to the attention of potential eligibles - methods which have called for ingenuity, imagination and resourcefulness. There was extensive use of all of the mass media, wide distribution of flyers and telephone and mail contact.

It is impossible to identify the number of new SSI applications that are attributable solely to Project SSI-Alert. It is clear, however, that the total effort has produced results that have improved life for well over a million persons.

On May 4, 1974, the Administration on Aging and the Social Security Administration issued memoranda to the SSI-Alert projects and Social Security district offices describing a renewed thrust, Phase II, to reach additional potentially eligible SSI beneficiaries. Up to one half the amount of Model Project funds granted per district office in the State for Phase I were granted to the States for Phase II implementation.

Phase II of SSI-Alert involves a mailing to the individuals included in the Social Security Master Beneficiary Record (MBR) leads list, with follow-up done by

SSI-Alert volunteers or Social Security personnel for those individuals who express an interest in applying for Supplemental Security Income benefits. Specific guidelines for Phase II implementation were issued on June 12 and July 12.

Over three-quarters of the States have continued some type of SSI-Alert activities into 1975. There was a realization that the outreach and follow-up efforts provided by the volunteer network in SSI-Alert offered a great potential for resolving a number of problems for older persons. Through coordination between the State and Area Agencies and the Social Security District offices in utilizing their information and referral services, the SSI-Alert is continuing as an ongoing part of outreach activities.

B. REHABILITATION SERVICES ADMINISTRATION

The major goal of the Rehabilitation Services Administration's program for the Aging is to rehabilitate as many older handicapped individuals as possible into gainful employment through activities of the State-Federal rehabilitation program administered by the agency.

The Rehabilitation Services Administration endeavors to assist each individual to reach his most adequate functioning level and highest potential. This is accomplished through a diagnosis of his condition followed by various services designed to overcome his specific handicap. Throughout the process, the emphasis is on helping the individual to help himself. These services include: evaluation and medical diagnosis to determine the nature and extent of the disability to ascertain capacity for work; counseling to help in developing a good vocational plan; medical care to reduce or remove the disability; vocational training and placement into employment; and follow-up to ensure satisfactory placement.

Progress in Rehabilitation of the Aging--It is estimated that there are over 4 million people 45 years of age and older eligible for, and in need of, rehabilitation services, of whom nearly 1 million are aged 65 and beyond.

In an effort to alleviate this, State rehabilitation agencies have been intensifying their efforts to serve the aged handicapped and a steady increase in the number of these individuals has resulted. For example in FY 1959, a total of 80,739 disabled persons were rehabilitated into employment, of whom 24,275 were aged 45 and over and 1,432 were aged 65 and over. In FY 1973, a total of 360,726 disabled persons were rehabilitated into employment 74,164 of whom were aged 45 and beyond and 5,069 were aged 65 and beyond.

Training-- Short-Term Training courses have served to focus on problems faced by older handicapped persons and stimulate interest on the part of professional rehabilitation staff, and staff from health, welfare, and other agencies who may attend, in developing methods and techniques to cope with these problems. A recent course sponsored by the Rehabilitation Services Administration and San Diego State College focused on vocational rehabilitation and the older handicapped worker. Staff from States in Region IX attended this meeting together with staff from appropriate public and private agencies in the San Diego area.

In 1971, a Short-Term Training course was conducted to prepare recommendations to be presented to the 1971 White House Conference on Aging.

Two Regional Short-Term Training Courses were conducted in 1973. One was held in Region IV in Clearwater, Florida and the other in Region II in New York City. Each focused on recommendations on rehabilitation voted upon by delegates to the White House Conference on Aging. RSA staff from States in these Regions attended, as well as staff from other appropriate public and private agencies in the Regions.

Special Activities in the State Agencies-State rehabilitation agencies have utilized expansion grants and Basic Support resources to expand their services to the aging disabled. For example, the Iowa rehabilitation agency has worked cooperatively with the Easter Seal Society in that State on a project for the home bound which serves a large number of older disabled people. Also, the Ohio rehabilitation agency has participated in a public housing project designed for the handicapped and senior citizens.

Currently three expansion grants are in operation focused on rehabilitation of the aged disabled on, or near, the poverty level into employment. Public Welfare recipients are also included in this grouping. These projects are located in New York, Illinois and Massachusetts.

Social Security Disability Applicants-The Rehabilitation Services Administration coordinates with Social Security Administration in utilizing the Social Security disability applicant load as an important referral source of older disabled persons for State vocational rehabilitation services.

Future Plans--The Rehabilitation Services Administration cooperates with the Administration on Aging in various activities such as Senior Citizens Month, White House Conference on Aging and other special projects and will continue to do so.

State Rehabilitation Agencies: Rehabilitated persons 45 years of age and over and 65 years of age and over at acceptance - Fiscal years 1973-1976.

Fiscal Year	All Rehabilitants	45 years of age and over	65 years of age and over
1973	360,726	74,164	5,069
1974	361,138	76,200	6,500
1975	363,000 1/	71,000 1/	5,800 1/
1976	332,000 1/	60,000 1/	5,300 1/

1/ Estimate

C. OFFICE OF RURAL DEVELOPMENT

The Office of Rural Development was established by Secretary Weinberger in June, 1973 for the purpose of "catalyzing and institutionalizing throughout HEW a concern for meeting the needs of rural Americans." The Office recognizes that the elderly comprise a particularly important group in rural areas. Although the elderly comprise ten percent of U.S. population in 1970, they made up approximately sixteen percent of all American living in non-metropolitan areas. Nearly one-third of these rural elderly live in poverty.

The Office is not an operating agency and has no program budget. Instead it is organized to impact on institutional processes of HEW which may improve the use of the Department's resources for delivering human services to rural residents. Examples of such processes include: intergovernmental relations, intradepartmental coordination, policy development, information sharing and capacity building through training and technical assistance.

The Secretary's mandate to the Office covers four specific areas of activity:

- To identify barriers to the delivery of HEW services in non-metropolitan areas;
- To design and recommend human service delivery systems for rural areas;
- To establish an internal network and coordinate those efforts with other Federal agencies for the purpose of delivering human services to target areas;
- To represent the Department on interdepartmental task forces concerned with rural development.

The Office is located within the Office of the Assistant Secretary for Human Development together with the Administration on Aging and other units serving special target populations. During FY 1974, the Office established a department-wide Rural Network which includes representation in each HEW Regional Office and major agency including the Administration on Aging. The Office is currently attempting to build the capacity of this Network to provide information and referral services with respect to HEW programs available to support rural development.

Other activities of the Office which may have indirect benefits for the rural elderly include: (1) a study of selected rural human service projects from which ORD expects to describe principal barriers to service delivery, set criteria and procedures for evaluating delivery systems, and determine characteristics of successful systems; (2) an analysis of HEW obligations to rural areas published by the Senate Subcommittee on Rural Development, Committee on Agriculture and Forestry; and (3) a contracted evaluation of the Concerted Services in Training and Education Program--a manpower and community development program devoted solely to rural areas.

D. OFFICE OF NATIVE AMERICAN PROGRAMS (ONAP) - FISCAL YEAR 1974

The Office of Native American Programs provides grants and contracts to Indian tribal groups, organizations and consortia to promote economic and social self-sufficiency with the primary emphasis being placed on community development. The programs do vary from one grant to another in accordance with the differing needs of different communities and with the differing priorities as identified by the Indian governing bodies.

No ONAP grant is specifically oriented towards serving elderly Indians, although of course, the elderly Indian would be part of the service population with all other Indians residing in that community.

Five ONAP grants do, however, have a Senior Opportunities and Services component and are listed below:

- Leech Lake Reservation in Minnesota for FY 75 is expending $45,484 of its $200,484 ONAP grant for a Senior Opportunities and Services component. There are approximately 400 elderly Indian poor in this community for whom visits and transportation are provided.

- The Cheyenne River Reservation in South Dakota for FY 75 is expending $49,385 of its total $264,385 ONAP grant for purposes such as hauling water and wood and for providing transportation for 304 elderly Indians.

- The White Mountain Apache in Arizona are utilizing $22,051 of their FY 75 $328,051 ONAP grant for Senior Opportunities and Services programs which include employment, recreational, referral and nutritional services.

- The Salt River reservation in Arizona is currently combining $19,080 of its $140,080 ONAP grant with EFMS and AOA money into one program for 300 elderly Indian people. The program serves 35 meals per day, provides fire wood, house and yard cleaning, minor repairs on houses and identifies medical needs.

- The Nevada Inter-Tribal Council is currently expending $52,000 of its $296,000 ONAP grant for a Senior Citizens Program which serves approximately 250 elderly Indians. The program has set up 14 centers which provide meals, opportunity for social interaction, field trips, craft workshops and the like.

II. SOCIAL SECURITY ADMINISTRATION

Programs Administered by the Social Security Administration

The Social Security Administration (SSA) administers programs which provide protection against loss of earned income due to retirement, disability or death for over 90 percent of the workers and their families in the United States. It also administers the Medicare programs, which provide hospital insurance and voluntary supplementary medical insurance protection for virtually all individuals in the United States who are age 65 or older, as well as for eligible disabled persons under age 65. Beginning January 1, 1974, the SSA also has been responsible for payments to aged, blind, and disabled persons under the Supplemental Security Income program which has replaced the State programs of aid to the aged, blind, and disabled formerly administered as grant programs by the Social and Rehabilitation Service.

Benefits to Older Persons

Under the retirement, survivors and disability insurance programs (title II of the Social Security Act) monthly cash benefits are paid to aged or aging persons, their dependents and their survivors. The following categories of older persons can receive monthly cash benefits:

-- Insured workers between the ages of 62 and 72 who have substantially retired from gainful employment.

-- Insured workers age 72 and over, without regard to work status.

-- Insured workers up to 65 years of age who have worked a specified period of time in covered employment and have a medically determinable disability, which can be expected to last for a continuous period of 12 calendar months, and which prevents them from engaging in any substantial gainful activity.

-- Certain individuals age 72 and over who are not insured under the regular social security program.

-- Wives or dependent husbands age 62 or over of retired or disabled insured workers.

-- Widows or dependent widowers of insured workers age 60 and over.

-- Certain disabled individuals age 50 and over who qualify as widows, widowers, or divorced wives of insured workers.

-- Dependent parents, age 62 or older.

Of the 30,600,000 beneficiaries receiving monthly retirement, survivors or disability insurance benefits at the end of October 1974, about 22,900,000 were age 62 or over. According to statistics updated to include January, 1974 approximately 91 percent of all persons age 65 and over either receive retirement, survivors or disability insurance benefits or are eligible for benefits on retirement. This proportion will grow until practically all aged persons are protected. The minimum monthly benefit for a retired worker who meets the regular insurance requirements is $93.80 under present law. For retired couples the present minimum is $140.70. This is subject to actuarial reduction if the benefit is taken prior to age 65. For those persons age 72 and older who qualify for uninsured (Prouty) benefits the payment to a single person is currently $64.40 a month and for a couple $96.60 a month. Average monthly benefits being paid at the end of December 1974 for retired workers was $188; for retired workers and their wives $312; for aged widows $177;

and for disabled workers $206.00.

Title XVI of the Social Security Act as amended, now provides for a Federally administered and financed Supplemental Security Income (SSI) program for persons aged 65 and over and for the blind and totally disabled. This program was effective January 1, 1974. It assures income of at least $146 per month for an individual and $219 per month for a couple. Under present law, in July 1975 the support levels are estimated to increase to $159 and $239.50 respectively. Certain income disregards included in the law allow some limited additional income, and encourage beneficiaries to work when they are able to do so. Lien laws are not applicable and, generally, beneficiaries may retain their homes and automobiles. Eligibility requirements and support levels are the same in all States. To assure that recipients of benefits under the former State administered programs for the aged, blind, and disabled suffer no loss of income under the Federal SSI program, States are required to supplement the Federal benefit. States may also supplement the Federal benefit payment to SSI recipients regardless of whether they are recipients "converted" from State assistance rolls to the Federal SSI program or newly eligible. States may administer their own supplementation payments or choose Federal administration. States which choose Federal administration have two advantages. First, the Federal government pays all administrative costs of making the supplementation payments; and second, States are protected, generally, from paying more out of State funds than they paid in calendar year 1972. Estimated federal benefit payments to the aged, blind and disabled under this program in fiscal 1976 will amount to $4.8 billion, of which $2.1 billion will be to persons age 65 and over.

On December 30, 1969, the President signed into law the Federal Coal Mine Health and Safety Act of 1969. The Act was amended on May 19, 1972. Benefit payments are made under this law from general revenues to coal miners who are totally disabled due to pneumoconiosis ("black lung disease") and to widows of coal miners who died due to pneumoconiosis. These benefits are increased if the beneficiary has eligible dependents. Benefits also are payable to orphans, and in certain circumstances to totally dependent surviving parents, brothers and sisters. Many of the beneficiaries are aged because the Act permits former coal miners and widows to qualify without limitations on either age or how long ago the disability occurred. In fiscal 1974, benefits paid to persons age 65 and over under this program were $662 million and in fiscal 1975 payments to such persons are expected to be $673 million and $735 million in fiscal 1976.

Health Insurance Benefits

In fiscal 1975, an average of 21,600,000 persons aged 65 and over and 1,900,000 disabled persons in the United States will be afforded basic Medicare protection. Under Medicare, hospital insurance beneficiaries are protected against the costs of inpatient hospital services, post-hospital skilled nursing facility services and home health services. In addition, the voluntary supplementary medical insurance program covers the cost of physicians and related services. Both parts of the Medicare program provide for payment of these costs subject to certain deductible and co-insurance amounts.

Payments to hospitals, extended care facilities and home health agencies for persons aged 65 and over under the hospital insurance program are expected to total an estimated $9.0 billion in fiscal 1975 and $10.3 billion in fiscal 1976. Supplementary medical insurance payments for aged persons in fiscal 1975 and fiscal 1976 are estimated to amount to $3.0 billion and $3.4 billion respectively.

Services to Aged Individuals and to Community Groups

The social security programs are administered through a network of district and branch offices. Local communities are served by 634 district offices, 644 branch offices, 3,434 resident stations and contact stations, and 24 teleservice centers. Every attempt is made to tailor services to individual needs and desires.

Thus, all offices provide face-to-face interviewing in the office or in the individual's home, telephone service, and mail service.

Social security district offices provide information to the public and answer inquiries about the benefits administered under Titles II, XVI, and XVIII of the Social Security Act. They also receive, develop, and initially adjudicate claims for such benefits. Applicants are assisted in securing the factual information needed to determine eligibility for benefits and are advised of their rights. For adult beneficiaries who are not capable of managing their funds, a person other than the beneficiary is selected by SSA to receive the checks and is held accountable for using the benefits in the best interest of the beneficiary.

Social security offices traditionally have provided a referral service to community members, groups, and agencies. In many communities the social security office is the only point at which information and referral services are available.

In the areas of community and Government-wide planning, SSA plays a vital role. Data about the numbers of aged, disabled, survivor, and health insurance beneficiaries is invaluable in planning services to meet existing needs, as well as in long-range planning endeavors. At the national level, SSA's planning is coordinated with planning of other departments, agencies, and organizations, both public and private, such as the Department of Agriculture, Public Health Service, Administration on Aging; Social and Rehabilitation Service, Department of Housing and Urban Development, ACTION, American Public Welfare Association, National Council on the Aging, and the American Red Cross.

Similarly, regional offices engage in planning and coordination of SSA activities at the regional level as these relate to other public and private agencies and programs that serve the aged. The advent of Medicare also required extensive interface with numerous organizations and facilities which serve the aged. To facilitate effective administration of the Supplemental Security Income Program, regional teams are providing important liaison between SSA and State departments of social service to assure that applicants and recipients of assistance payments are referred to both agencies as appropriate.

At the State level, SSA provides assistance to State health departments to fulfill Medicare requirements and to promote full potential for care of the aged in institutions, out-patient, and home care facilities. More recently, very extensive coordination with States was required for implementation of the Supplemental Security Income Program.

At the local level, SSA participates in interagency community planning for development of resources with many health and welfare agencies. These include representatives of health and welfare councils, local government officials, local representatives of national public and voluntary agencies such as ACTION, U.S. Department of Labor, National Council on Aging, County Commissions on Aging and senior citizens groups, American Red Cross, etc. Projects resulting from this participation often involve substantial numbers of older people recruited to perform a variety of activities throughout the community as well as in SSA offices. Examples of these activities include outreach programs such as FIND, Medicare Alert, and SSI Alert, in which older volunteers contact vast numbers of potential aged individuals to assure that all who are eligible take advantage of income, health, and welfare programs available to them. Social security offices cooperate with all such projects and provide training to volunteers on eligibility requirements, procedures, etc. While some aged workers are volunteers, others are paid nominal amounts by ACTION under the RSVP and Foster Grandparents programs or by the Department of Labor under contract with local groups serving the aged. Most older people working in social security offices are paid, and work part-time, performing clerical, and sometimes higher level functions. Projects and activities such as those described, sponsored by the government and by private agencies, have clearly demonstrated the effectiveness of older worker performance as well as advantages to the retiree and to the employing agency.

Research on Economic Security for the Aged

The Social Security Administration research and statistical program provides information derived from the operations of the Social Security Administration system, from population surveys and from studies of related public and private income maintenance programs that is useful for continuous evaluation of the effectiveness of the social security program in providing economic security for the aged, including protection against the costs of hospital and medical care. Data are developed and published regularly in the Social Security Bulletin and its Annual Statistical Supplement, in special published reports and in various other ways to meet user requests.

Indicative of the types of information made available and of interest to officials and groups planning programs for the aged are: continuously reported data on claims and benefit payments to retired workers and their dependents; the findings of surveys of the aged population, which provide information about the level of economic security that social security benefits support (information obtained on income includes sources of income of individuals and families, level and types of assets owned, special demands on income such as medical expenditures, etc.); special studies that show the changing share of the total national output going to the aged, what measures of income adequacy are most appropriate and meaningful, the relationship between individual and family income over the life cycle; continuing statistical series that are concerned with the totality of public and private income maintenance protections and the relative weight of the social security program in that totality; and research to measure the impact on the aged of both public and private health and medical care programs, to identify and define gaps and unmet needs under the health insurance program, and to examine and evaluate the economic consequences of the health insurance program. Social Security Administration research draws heavily upon basic data in the social security system, data from the population survey program, and upon data from the Bureau of the Census, Bureau of Labor Statistics, and other statistical sources.

III PUBLIC HEALTH SERVICE

A HEALTH SERVICES ADMINISTRATION

1. COMMUNITY HEALTH SERVICES

The Bureau of Community Health Services was established to help find the best ways to meet the health care needs of communities. Its goal is to ensure optimum health for the total community, with particular focus on the medically-underserved areas of the nation. While the aged, per se, are not a special target population for Bureau programs, they are included among the beneficiaries of overall community health improvement activities. Within the Bureau, improved health of the aged is promoted through community health centers, migrant health projects, health maintenance organizations and the National Health Service Corps.

Community health centers are designed to provide ambulatory health care services primarily for the poor and the working poor. During FY 1974 a total of 157 such centers provided primary health care to approximately 1,235,000 persons. These persons reside generally in rural or inner city areas which are medically underserved. It is estimated that 6 percent of the persons registered for service in these centers are age 65 and over.

The Migrant Health Program provides access to health care services for migrant and seasonal farmworkers and their families. Migrants live and work in predominately rural areas where health resources are scarce. As a group, the migrant family represents an underserved segment of the population in terms of most social and health services. The elderly migrant, generally uneducated, often unable to speak English, and usually incapable of participating in the work force, may present even greater needs than the rest of the migrant family. Of approximately 355,000 migrants and seasonal farmworkers who received services during 1974, it is estimated that 4,000 are 65 years of age or older.

Health Maintenance Organization (HMO) legislation was passed late in 1973, authorizing a program to demonstrate the feasibility of prepaid health maintenance organizations as an alternative mechanism for delivery and financing of health services. While HMO services are available to all persons in a given geographic area who enroll in the HMO, the emphasis on accessibility, prevention, quality of care, efficiency and cost consciousness makes this health care option particularly valuable to the aged, in view of their higher-than-average utilization of services. Since the inception of the Medicare program, such prepayment plans have been authorized to request reimbursement for physician services on a cost basis. In 1974, 39 plans with a Medicare enrollment of 335,000 beneficiaries were receiving reimbursement.

Further, Section 226 of the 1972 Amendments to the Social Security Act contains a provision allowing SSA to make reimbursement to HMOs for physician, hospital and other institutional services. Regulations setting forth the qualifications an organization must meet to be eligible for a

Medicare HMO contract were published in the Federal Register as proposed rulemaking on August 27, 1974. Related regulations on reimbursement, enrollment and the like are under development.

The National Health Service Corps is designed to improve the delivery of health services to persons residing in areas with critical manpower shortages. Older people living in such areas often lack mobility and availability of health personnel in their communities is of special importance to them. The program goal is to place health professionals who will establish successful practices in shortage areas and continue to provide services in these areas. By the end of FY 1974 there were a total of 392 health professionals assigned to 193 shortage area communities.

In summary, programs of the Bureau of Community Health Services, while not specifically designated for the elderly, serve all persons residing in their project areas. Many of the projects are located in areas with high concentrations of elderly persons and offer for them the only available health resources. It is the goal of the Bureau to continue its efforts to serve this needy group.

2. PROFESSIONAL STANDARDS REVIEW ORGANIZATION

The Professional Standards Review Organization Program was authorized by the 1972 amendments to the Social Security Act. This provision requires the Secretary to establish and support a nationwide network of voluntary, non-profit groups of local physicians to regulate the quality of health care services paid for under Medicare, Medicaid, and Maternal and Child Health Programs. The purpose of the statute is to improve the quality of health care services and to make more cost effective the expenditures for health care services financed by Titles XVIII, XIX, and V of the Social Security Act. PSRO's are to accomplish these purposes by applying sophisticated concepts of peer review through a system of voluntary local organizations, State Councils, and a National Council supported, regulated, monitored, and evaluated by the Federal Government.

PSRO's will review the medical necessity of services, the quality of care delivered, and the appropriateness of the care in terms of the level, duration, and methods of treatment. In reviewing medical necessity and quality, PSRO's will be determining whether health care services provided are necessary on the basis of professionally developed standards of norms of care, diagnosis, and treatment. In reviewing appropriateness, PSRO's must determine whether the level at which health care services are provided (e.g., inpatient, outpatient, intermediate care) is the most efficient as well as the most effective level. This peer review system will assure that payment is made from Federal and state funds for only medically necessary, appropriate, and quality care.

Initially, PSRO's will place emphasis on the review of institutional services, especially those provided in the acute general hospital. Eventually, the scope of their review will be expanded to encompass all facets of the health delivery system.

The PSRO program relates closely to and must be integrated with other health care review activities required by the Social Security Act particularly as the Act was amended in 1972. The PSRO legislation intends that utilization review and other duplicative review activities will eventually be eliminated and PSRO's will assume responsibility for such activities. To this end, the final utilization review regulations published in November 1974 for Medicare and Medicaid were designed to facilitate effective in-house review capability and thereby expedite the establishment of the PSRO program.

In 1974 the country was divided into 203 PSRO areas designated by the Secretary of DHEW. By early 1975, 102 areas were funded with conditional PSRO's (11) and planning PSRO's (91).

The eleven conditional PSRO's funded in late FY 1974 and the two funded by mid-FY 1975 began operation of their review systems in short-term general hospitals. The hospital peer review system that these PSRO's are using is an integrated one, which includes concurrent review, medical care evaluation studies and profile analysis. FY 1975 also includes converting 36 planning and one new conditional PSRO.

The complex operational nature of the program, coupled with statutory requirements, result in the need for a significant array of policies and regulations. The PSRO Manual initially published in April 1974 and since updated and expanded, contains interim program policies which are guiding the PSRO's. Many of these and additional policies will be published as regulations in 1975.

To assure accountability, monitoring, sound management and evaluation, a uniform information and reporting system will be implemented in 1975 which will include cost data, performance data on review activities, and overall administrative and management data.

PSRO activities during 1976 will focus on the following major objectives: continuation of the conditional PSRO's initiated in 1974 and 1975; converting an additional 31 of the 55 planning PSRO's to conditional status, and funding up to 3 Statewide Councils; funding remaining 24 planning PSRO not yet converted to conditional status; implementation of all regulations issued during 1975; and coordination of the End-Stage Renal Disease (ESRD) and PSRO programs. About 81 conditional PSRO's will be in existence by the end of 1976.

Another important objective for 1976 relates to the evaluation of the impact of the PSRO program on the quality and utilization of health care services financed under Medicare, Medicaid, and Maternal and Child Health programs.

3. QUALITY ASSURANCE

When Medicare was enacted in 1965, the Secretary of HEW was required to establish national conditions of participation for a variety of providers of services to protect the health and safety of program beneficiaries. Prior to Medicare, little existed in the way of established professionally acceptable standards for some providers of services, particularly for long-term care facilities, home health agencies, and independent laboratories. Qualifications required for many types of health care manpower also were inadequate to ensure a safe level of quality of services. The Division of Provider Standards and Certification of the Bureau of Quality Assurance, working with the Social Security Administration, was assigned principal responsibility for standard-setting and surveillance of the program, and for other professional health aspects of Medicare of direct benefit to program beneficiaries.

The objective of the Division of Provider Standards and Certification is the improvement of the health status of Medicare and Medicaid beneficiaries by ensuring that the types, quality, and quantity of services provided under the program are appropriate to patient needs. Since the beginning of the program, the effects of the standards, along with their continuous evaluation and revision, have been to promote the upgrading of individual institutions and agencies, to improve State licensure and certification programs, and to stimulate changes in national (non-governmental) accreditation programs. In establishing standards and surveillance techniques for individual health care practitioners, problems of qualifications and availability have proved difficult. However, Medicare has helped to focus attention on problems of health manpower--from physicians to nurse aides--including their supply and the surveillance of the services they provide. A variety of techniques for assuring quality of services under Medicare and Medicaid, without unduly limiting the supply of health care personnel, including the utilization of proficiency examinations for designated categories of such personnel (e.g., physical therapists, practical nurses licensed by waiver, clinical laboratory technologists, cytotechnologists, psychiatric technicians) have been employed and are continually evaluated by the Division of Provider Standards and Certification.

The Conditions of Participation for Skilled Nursing Facilities and Intermediate Care Facilities, together with interpretive guidelines for use by State agencies and providers, were revised and issued in 1974, as were the Conditions for Coverage of Services of Independent Laboratories. Importantly, the revised regulations for skilled nursing facilities include special provisions for upgrading the quality of medical direction in these facilities, for improving discharge planning, and for safeguarding and ensuring patients' rights. Similar efforts are being made to revise and update, in 1975, the Conditions of Participation for Hospitals. Work is currently in process to revise and update the regulations pertaining to the provision of Outpatient Physical Therapy and Speech Pathology Services, and regulations for the Independent Practice of Physical Therapy are also being developed. The Division has also participated in the development of proposed regulations for End Stage Renal Disease Services covered under Medicare; final regulations and interpretive guidelines will be issued in calendar year 1975. Experimentation and developmental activities are currently underway in the area of standards to ensure the quality of services provided in ambulatory health care centers. The Division has also directed attention to the problems of fire safety in long-term care facilities and, under contract with the American Nursing Home Association, is conducting a study ("Nursing Home Burn-out Study", involving onsite burn-out testing) that should

lead to the identification of needed modifications to the Life Safety Code of the National Fire Protection Association. As the Department's operational focal point for the interagency coordination of such efforts, the Division has worked in close collaboration with other health agencies in the Department, with the Bureau of Health Insurance, SSA, and with the Medical Services Administration, SRS. Training and enforcement activities related to these efforts have continued, and new initiatives have been made along several fronts in the area of training, with Division headquarters and regional office personnel closely collaborating with headquarters and regional office staff of BHI and MSA.

The Division has participated in several ongoing programs designed to promote and maintain the quality of care provided to elderly persons. For example, the Division has provided support to the Bureau of Health Insurance and Medical Services Administration regional office staff in the conduct of comprehensive program reviews of State Medicare agencies; these reviews are a means of assessing the effectiveness of program policy and guidelines and the manner in which these are administered in the States. Through the provision of consultative and technical assistance, and other support activities, the Division has been involved in and has continued to promote quality assurance mechanisms, such as utilization review and those fostered under PSRO programs.

Another ongoing comprehensive program instituted in 1970 was to improve the interpretation and uniform application of Federal health care programs by State agency personnel through training and evaluation of individual surveyor performance. This program was developed to meet a specific need following the enactment of Medicare and Medicaid, and has been supported by the States, the Social Security Administration, and the Social and Rehabilitation Service, all of which have assisted in its development. The health facility surveyors who are being trained through university-based and university-sponsored courses have a major responsibility for ensuring that long-term care facilities, hospitals, and home health agencies, and other providers and suppliers of service, provide safe and adequate care and comply with required standards in serving Medicare and Medicaid beneficiaries. The surveyor training programs have included basic and university-based and -sponsored courses for surveyors; university-based managerial courses for State survey agency supervisors and administrators; and indepth specialty courses covering various health care services. Since the inception of the program, 2221 State surveyors and 309 Federal employees have completed the courses. Programmed instructions for on-the-job orientation of new surveyors are currently in use at the State level.

Still another way in which the Division has a relationship to the health services for the aged is by recommending changes in Medicare policies and legislation, and in conducting studies. Some of these recommendations and studies have directly affected the accessibility, quantity, and quality of care in the Medicare program.

4. BUREAU OF MEDICAL SERVICES

The Bureau of Medical Services (formerly the Federal Health Programs Service) has no programs which of themselves relate directly and specifically to aging. This applies to its research and clinical care programs as well as to the programs of the Divisions of Emergency Medical Services and Federal Employee Health. For fiscal year 1974, of a total of 27,593 discharges from hospitals of the Bureau of Medical Services, 3,783 were aged 65 or over. The average length of stay for elderly men was 23.6 days and for elderly women 18.2 days, compared with an average length of stay of 16.8 days for all patients. Consistent with this finding is the fact that older patients are affected to a greater extent by chronic conditions which require longer periods of hospitalization, and for similar conditions, older patients tend to receive longer periods of hospital care than younger patients.

A high proportion of elderly persons receiving in-patient services are American seamen, who constitute the primary beneficiary group cared for in Public Health Service hospitals. The problems presented by this group of patients are similar to those presented by aging patients in general with one exception: there are probably more single males in this group than in the general population. Because of this, finding suitable nursing homes for their long-term care constitutes one of the real problems in meeting the needs of aging patients served by the Bureau of Medical Services.

PLANS FOR 1975

During 1975, Bureau of Medical Services proposes to establish a Day Treatment Center for the Elderly at the United States Public Health Service Hospital in Baltimore, Maryland. This program will provide an alternative to institutionalization for elderly patients by providing supervision and personal care services to older persons with physical, mental or social impairment. The capacity of families to continue helping to maintain elderly relatives at home is depleted when no respite is available and institutional placement is often made not because the older person needs institutional care but because the right kinds of assistance needed do not exist. The Day Treatment Center should solve some of the difficulties of daily living, provide respite to families with elderly relatives, and enable the older person to return at night to the home setting. The aged indicate a strong preference for remaining in their homes and the Day Treatment Center would greatly assist both the family and the elderly in this regard.

The Day Treatment Center for the Elderly will be an organized program of activities and health services offered during the day in a protective group setting for purposes of personal care and designed to activate, motivate and retrain the elderly to sustain or regain maximum functional independence. The program objectives are as follows:

1. Enhance activities of daily living by providing instruction in self-care, health maintenance, consumer protection and money management and referral to other services required to assist the aged to remain in or return to their homes or communities.

2. Increase effectiveness of the individual through the service and consultation of experts not represented on the staff to develop health care plans to meet the needs of individual applicants or development of general program.

3. Improve health status by providing necessary diagnostic, remedial or treatment services and arrangements for obtaining physician or hospital services in case of emergency and by maintaining necessary liaison with other providers of health services to assure the provision of Center services necessary to carry out medical recommendations.

4. Reduce isolation by providing the means for aged persons restricted in their mobility to get out of the house; and encourage regular attendance on individually scheduled days by providing transportation incorporating safety features for the aged.

5. Promote socialization by offering companionship in a pleasant, safe and comfortable environment.

6. Stimulate interests by offering satisfying leisure time activities and discussion of common problems.

7. Conserve family interest and support by offering respite as required during part of all of the work week and by providing individual and group counselling.

Individuals participating in the Center will be aged persons referred from Public Health Service beneficiary groups, the Geriatric Evaluation Service of the Baltimore City Health Department, community organizations and private physicians.

B. NATIONAL INSTITUTE OF CHILD HEALTH AND HUMAN DEVELOPMENT, NATIONAL INSTITUTES OF HEALTH

The number of persons 65 years old and over has sharply increased over the years since 1900. The percentage of people over 65 years in the population has increased from about 4% to approximately 10%. In 1900 the average lifespan for a person in this country was 49 years; today it is 71 years. Primarily responsible for this increased life expectancy has been a decrease in mortality from infectious diseases.

Today there are more people in the population 65 years of age and older than there has ever been in the history of this country. Consequently, there has been an increasing awareness of the deterioration in biological, psychological and social processes with age. Scientists are striving to learn more about the changes that accompany aging in an effort to exert greater control over these deteriorative changes. These are the concerns of the National Institute of Child Health and Human Development as the Federal agency with primary responsibility for supporting research on aging. The aim of this research is to provide information that will make it possible for the elderly to live healthier and better adjusted lives. Such improvement in health can be expected to lead to a longer average lifespan.

The Institute in addition to supporting research in universities, medical schools and other research institutions around the country through the award of research grants also has staff scientists who conduct research at its intramural Gerontology Research Center in Baltimore. An extramural program of research grants in aging is supported by the Adult Development and Aging Branch of the Institute.

On May 31, 1974 the President signed legislation which provides for the establishment of a National Institute on Aging. The National Institute on Aging has been established at NIH although it is not fully operational in early 1975. When it becomes operational the NICHD programs in aging (the Adult Development and Aging Branch and the Gerontology Research Center) will be transferred to it.

1. THE EXTRAMURAL PROGRAM ON AGING RESEARCH

The Institute has identified certain areas of research on aging as areas of special need or that hold special promise. These areas of research compete equally for available funds, however. Several of these areas are described below.

a. Biomedical Aging

During development and after maturation various deleterious changes occur in the human body. Because the body does not possess the abilities to repair all these changes, some accumulate and result in the progressive deterioration called aging. At present, medical intervention can compensate for a small part of aging damage. One of the major aims of biomedical research is to make more extensive compensation possible. For example, intervention is already possible in the treatment of the menopause, the condition that results from ovarian aging. Probably in the future, physicians will be able to intervene more vigorously than now in the severe immunological deficiencies of the elderly. An understanding of the basic processes of cellular aging may open a number of therapeutic possibilities. Research in these areas: the menopause, immunological aging, and the cellular basis of aging is discussed below.

1) The Menopause. The variation in ovarian production of estrogens over the lifespan is remarkable. Estrogen production increases dramatically at puberty and declines drastically at the time of the menopause. Between puberty and menopause a gradual deterioration of ovarian structure occurs and is responsible for the diminished output of estrogens. The decline in estrogen output is clearly associated with hot flashes and genital atrophy. Indeed these changes can be reversed by the oral administration of estrogenic substances.

Some physicians suspect that some other deteriorative changes such as rarefaction of bone and arteriosclerosis may be due to the ovarian failure that causes the menopause. However, a causative relationship between ovarian failure and those diseases has not been definitely established.

Although it is clear that estrogen therapy of the menopausal and postmenopausal woman has beneficial effects, it is possibly not without risk. In view of firm data on increased thromboembolic disease in women on oral contraceptives, the risks and benefits of replacement therapy need careful examination, particularly since it is estimated that 13% of postmenopausal women are currently taking some type of intermittent replacement therapy.

The menopause, its sequelae and treatment have major public health implications, since it affects the health and well-being of a major segment of the population. Studies on the mechanism triggering ovarian involution, estrogen sources and production, as well as studies on the risks and benefits of sex steroids are needed to understand the menopause and its relationship to aging processes and degenerative diseases.

The Institute supports research on sources of estrogens other than the ovary in postmenopausal women. The Institute funds by contract a retrospective study of the effects of estrogen therapy on the occurrence of stroke and hypertension. Also, grant supported studies are currently underway that are aimed at acquiring information and data on understanding the mechanisms involved in ovarian involution.

2) Immunological Changes. Immunology emerges today as an important area for the study of aging because the changes that occur in immunologic competence with age underlie the increased susceptibility of the elderly to infectious diseases. The importance of the immune system as a defense against infectious diseases has long been known. While the young remain healthy because of a highly efficient immune system the elderly with their declining immune response are particularly susceptible to infectious diseases. It is also recognized that immunologic competence may play an important role in preventing the development of cancer and autoimmune diseases.

Fuller understanding of the nature of the deterioration with aging will permit design and application of measures to benefically modify immunity. At our stage of progress primary emphasis must be directed at defining the immunologic deficiencies of the aged at the cellular and molecular level. The development of new means to augment immune competence in the later years of life would represent a major advance in improving the health of older people.

3) Cellular Aging. Although complex systems such as the endocrine and immune systems may be modified to control some aging manifestations, more vigorous intervention might be possible if the cellular and subcellular aging processes damaging these systems were understood. Little is known about

cellular and subcellular aging. The progress of modern biology has, however, provided methodology and concepts to investigate the processes involved. Because cellular aging underlies much of what is manifested in the aged, the Institute places special emphasis on this area of research.

Through tissue culture and transplantation studies, scientists have learned that normal mammalian cells cannot reproduce themselves indefinitely. This fact has caused a profound change in theories of aging by emphasizing that an understanding of organismic aging may have to be based on cell biology.

The cell whose limited ability to reproduce itself has been most intensively studied to date is the fibroblast. This cell, which is similar to most dividing cells within the body, may provide a model for them and at the same time has its own importance as a producer of collagen and mucopolysaccharides. These substances form the structures which give mechanics to the cells of the human body. The Institute is supporting research on many aspects of the limited reproductive potential of fibroblasts, for example, membrane, mitrochondrial, and lysosomal function, protein and nucleic acid metabolism, peroxidation reactions, and hormonal responsiveness. Further, considerable effort is currently being directed to an expansion of this program to include more cell types representative of a variety of human aging phenomena. It is hoped that these and other studies will disclose the mechanisms by which cell reproduction potential and other functions are limited and the consequences of such limitations or the effects leading to them. Such discoveries will be particularly important if they can be generalized to other cells and tissues within the body.

b. Mental Aging

Decline in intellectual ability with age is of great interest to the Institute and is becoming of increasing concern in a society which has increasing numbers of older people.

Current knowledge of changes in the higher mental processes during the adult years has been based mainly on comparisons between young and old persons. Since the younger persons probably have better educational backgrounds the test results are likely to be biased in favor of the young. However, the results of such studies strongly suggest that there is deterioration in mental function with age. This deterioration is much more severe in non-verbal than in verbal abilities. The mechanism of this change is not known. However, it is thought that it may be related to the progressive loss of brain cells that occurs with age. The decline in mental function just described does not incapacitate an individual and can only be detected by special tests.

However, other more serious impairments of mental function may occur with aging. For many years, the severe cases of mental deterioration in the elderly were attributed to vascular disease. There is increasing evidence that this is not usually the case, and that, in fact, most instances of senile dementia are due to changes in the brain cells produced by some unknown mechanism. The Institute is supporting studies aimed at determining and ameliorating these changes.

There is interest in research aimed at determining which changes or degree of change in mental functioning as measured by intelligence tests and tests of cognitive ability can be attributed to age and what changes to some other

factor or factors. Much of the research on change in mental function has been complicated by the intermingling of several factors. For example, there are cohort differences and there are age differences which until relatively recently were not distinguished.

c. Social Aspects of Aging

The average lifespan has changed tremendously since the evolutionary emergence of mankind and there have been concomitant changes in the age-structure of the many different populations that have populated the earth. There is no reason to think that the population age-structure will not continue to change and it is conceivable that there will be major changes in the average length of life.

Basic to the process of planning for the health, social and economic welfare of the older population is an adequate understanding of its future size and composition. How this country's population size and age-structure develop in the coming years will be determined primarily by its future fertility and mortality rates. There is a growing need for appraising the impact of potential medical control programs in affecting morbidity and mortality levels for specific diseases and causes of death. There is increasing importance of mortality as a factor influencing population change especially under conditions of lower fertility rates and movement towards a stabilized population. In connection with these concerns for the demographic aspects of aging populations the Institute is supporting a survey of existing population models with an eye toward suggesting more rigorous and realistic methods of forecasting mortality trends.

2. INTRAMURAL RESEARCH

The Gerontology Research Center (GRC) remains the focal point for research on the aging processes within the National Institute of Child Health and Human Development and the NIH.

The 154 scientists, technicians and supporting staff of the Center study the physiological, biomedical and behavioral aspects of aging in both humans and a number of animal species. Their overall goal continues to be directed toward gathering fundamental knowledge of aging that can be used effectively by physicians, other professionals, and the public to enhance the quality of life for all older people.

The Baltimore Center, in addition to its own programs, houses a guest scientist contingent with more than 50 non-government personnel working on projects related to aging, or the illnesses that afflict older people most frequently. Research advances this year at the GRC follow.

a. Learning Body Control

One of the most depressing and debilitating infirmities of the elderly is the loss of control over excretory functions. Such losses cause considerable hardship for the family caring for an older person, and often this disability forces the family to place the patient in a nursing home.

A clinical research project of the Laboratory of Behavioral Sciences, in collaboration with physicians from Baltimore City Hospitals, proved that some patients can learn voluntary control over their excretory functions. This held true for patients ranging in age from six to 60 years. Some of the patients had suffered severe soiling problems for as long as eight years, and all of them had a history of organic disease which underlay the incontinence.

The technique involves operant conditioning (training by reinforcing correct behavior) and feedback to the patient. In these studies the patients were taught to control a specific reflex response of their bowel by watching a needle trace that response, and by being instructed (reinforced) in the correct nature of that response. Such learning is rapid, and complete training in all cases was accomplished in four or fewer training sessions.

Further applications for this treatment now are being tested in additional incontinent patients and in persons suffering other lower digestive tract disorders.

b. Teaching the Elderly

One of the most durable adages about older animals and people is that "you can't teach an old dog new tricks". However, animal experiments by an investigator in the Laboratory of Behavioral Sciences show it is possible to teach old rats tasks which they were unable to perform previously.

An old animal has trouble learning its way through a complicated maze because it tends to make the same error again and again, something a young animal seldom does. That is, it returns to the same alleys (deadends) in the maze even though previous experience should have taught it to avoid such an error. In the GRC study, training designed to prevent initial errors helped the old failures become efficient performers.

Therefore, it should be possible for older people to learn new tasks by designing learning situations which prevent errors during initial training.

c. Drug Metabolism in Adults

The effect of aging on the body's ability to distribute and metabolize drugs has received scant attention in the past. Therefore, the Baltimore Longitudinal Aging Study offers a unique opportunity to study such effects. This long-term study involves some 650 community-dwelling men, aged 20-96 years, who visit the Gerontology Research Center periodically to take numerous tests measuring age changes.

Scientists in the Clinical Physiology Branch selected two drugs, both metabolized by the liver, but by different mechanisms, to assess age changes. Alcohol was chosen because of its widespread use, its physiological effects, and the profound clinical, legal, and social problems involved in its use. The other drug, antipyrine, was picked because it represents a drug family metabolized by another basic liver mechanism.

Both drugs were given intravenously to volunteers whose chronological ages covered the adult life span. The study shows that alcohol is metabolized as well by older men as it is by younger men.

On the other hand, the ability to dispose of antipyrine decreased with age. An analysis of data on smoking and coffee or tea drinking habits, collected routinely on members of the longitudinal group, suggests a possible reason for the slower metabolism of antipyrine in older men. Both habits, regardless of age, speed up antipyrine metabolism. However, cigarette smoking and coffee or tea drinking declines in older volunteers. This indicates that much of what appears to be a decrement related to biological aging may be attributed more to age-associated changes in habits.

d. Age and Standards of Normality

Clinical scientists are becoming more and more interested in the concept of "normality" as it relates to treatment of aged patients. The identification of disease and classification of its severity depends on accurate age-corrected standards of what is normal.

Recently, such standards became available for the 24-hour creatinine clearance test which is a measure of kidney function widely used for clinical diagnosis. Studies in the Baltimore Longitudinal Aging Study reveal that the change in creatinine clearance with age is progressive and becomes evident even in the early adult years. The data clearly demonstrate that these age changes are not secondary to the increasing prevalence of kidney disease with aging but are due to true biological aging.

From these data, a nomogram has been developed by Clinical Physiology Branch investigators which allows the physician to compute easily the rank or score for each patient as compared to that of normal subjects of the same age. Use of this nomogram should help improve clinical diagnosis and treatment of kidney ailments in older patients.

e. Obesity Measures

Obesity is a known high risk factor in the development of coronary heart disease, diabetes and other diseases as well as being a predictor of mortality. Accurate assessment of obesity in large numbers of people is extremely difficult. Height and weight tables are useful but limited because they fail to separate increased weight due to fatness from that due to muscularity.

Measurements of body composition have been taken for the past 15 years in Baltimore Longitudinal Aging Study subjects examined every one to two years. Since both weight gains and losses occurred in these men as they aged, various indices of obesity can be related to weight changes. The nature of the study itself made it possible to test the accuracy of measures used to indicate obesity. Two methods widely used to augment height/weight data were tested. One measures body circumference, abdominal girth for example, and the other estimates layers of fat under the skin using pinch calipers.

The experience of these studies shows that lower abdominal circumference is far superior to skinfold measures as an indicator of fatness. Furthermore, changes in girth effectively reflect weight changes in young, middle-aged and old adults. The use of this measurement should greatly improve evaluation in programs directed toward improving the health status of the aged.

f. Hormonal Response in the Old

One fairly common manifestation of aging is a general decrease in the body's ability to respond to various stimuli. One reason for this is the older organism's reduced capacity to make the correct biological response to hormones, in particular those from the pituitary and adrenal glands. Initiation of these responses requires the binding (attachment) of hormones to specific target sites of various tissues.

Animal studies carried out in the Clinical Physiology Branch show that these crucial hormone receptor sites are partially lost during aging. This helps to explain some of the reduced responses to certain hormones known to occur in aging animals and humans.

g. Aging Effects on the Heart

The ability of the heart to contract optimally and to respond to exercise and to other life stresses has been shown to diminish in both experimental animals and man with advancing age. The mechanisms underlying this aging effect are now being studied in heart muscle preparations of old and young rats.

These studies by the Clinical Physiology Branch show that the tension developed with each beat is unaffected by age, but the time required to generate this tension is significantly prolonged in the aged heart. The mechanism of this prolonged contraction appears to be related to abnormalities in the active heart relaxing system, namely, a delay in the removal of calcium from contractile elements. Furthermore, the response to stress, elicited by exposure of the heart muscle to adrenalin is significantly diminished in the aged heart.

These results suggest mechanisms which may explain age-associated changes in the cardiovascular system. An understanding of these mechanisms would prove extremely useful in the diagnosis and therapy of older cardiac patients.

h. The Aging Immune System

Past studies by investigators in the Laboratory of Cellular and Comparative Physiology revealed that the loss of normal immunity that accompanies aging results, mainly, from changes in the body's own immune cells. This is reflected in their lessened ability to reproduce themselves and become efficient disease fighters. Thus, the older person becomes highly susceptible to diseases which are effectively controlled by the immune system in younger people.

This year, these investigators found one possible way to bolster immunity in the old. Thymic and bone marrow tissues taken from young animals and transferred to old mice led to restimulation of the immune system in the old animals. This indicates that the immune system in the old can be strengthened although transplanting young cells may not be the best method to use. The GRC scientists are searching for a number of other ways to improve the efficiency of the immune system in older people.

i. Cellular Aging

A decline in cellular proliferation of certain tissues is an important feature of human aging. An understanding of the molecular mechanism is crucial, for it will contribute to our knowledge of human aging at the cellular level.

Researchers in the Laboratory of Cellular and Comparative Physiology examine cultured human fibroblast cells which have a diminished ability to divide as they age. They have found a generalized increase in these cells' large molecules, such as proteins and ribonucleic acid, which are necessary for maintenance of cellular integrity. Further studies are aimed at delineating the relationship between age-related cellular accumulation of large molecules and cellular replication.

j. Age and Impaired Cell Communication

All cells depend on the efficient communication of genetic information for their survival. In other words, messages must be sent from genetic headquarters (the nucleus) to the living area of the cell (the cytoplasm) to trigger production of proteins needed to maintain cell life.

Metal ions (trace metals) in small amounts are necessary for the effective transmittal of these genetic messages. However, earlier studies in the Laboratory of Molecular Aging showed that metal ions present in excessive amounts produce errors in the transfer of genetic messages. Furthermore, studies of human cells in tissue culture show that the concentration of metal ions rises markedly with age.

These investigators have now found evidence suggesting that one way ions contribute to deterioration of cell genetic information is by shortening message units sent from the nucleus to the cytoplasm.

C. ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

Persons over 65 years of age constitute more than 10 percent of the population and occupy 28 percent of all public mental hospital beds; but they receive less than 2.3 percent of outpatient psychiatric services. About 5 percent of the aged population are in some form of institution. Approximately four-fifths of the institutionalized aged are in nursing homes, homes for the aged, and personal care homes. Fifty-six percent of all nursing home residents are considered to be "senile."

Because of the high susceptibility of this age group to physical and mental illness, the health problems posed are far greater than would be expected on the basis of the population figure alone. While it is true that many of the mental health problems common to other age groups are also prominent among the aged, this group in addition is vulnerable to specific difficulties associated with the aging process. Some of the mental impairment of the aged is a concomitant of physical aging and 42 percent of elderly persons not in institutions suffer from limitations in their activites because of chronic conditions. The psychological reaction to this physical process may form the basis for excess impairment that cannot be attributed to organic changes. The high incidence of depression, suicide, withdrawal, and regressive responses on the part of older people provides a crucial area for attention by the National Institute of Mental Health. The handicaps also imposed by nonacceptance and loss of status in a youth-oriented society accelerate the psychopathological reactions occurring within older persons.

Faced with a public mental health problem of this magnitude, the NIMH has attempted to mobilize its resources to maintain, and if possible, to improve the mental health of this segment of the population. By the active support of research, the development of innovative and more effective methods of delivering mental health services, and the education and training of appropriate manpower, the NIMH is seeking to provide increased and more precise knowledge of the factors associated with mental health and mental disorder in later life, to devise means for preventing mental disorder and maintaining the psychosocial functioning of older persons, and to stimulate greater interest and more adequate programs for the elderly on the part of the various public and private agencies and institutions responsible for the mental health and welfare of the American public.

1. NORMAL AGING

Although the elderly display many of the mental health problems and concerns found in the general population, certain areas of special importance requiring focused effort can be identified and are being pursued by NIMH staff. One basic problem is the need for more accurate and detailed information about the aging process and the methods of adjusting to it. A common view of later life is one of pessimism in which abilities and satisfactions decline rapidly and with significant physical, psychological, and social deterioration seen as being inevitable. A recent publication emanating from an NIMH-supported project describes an intensive and comprehensive study of healthy old men in which the biomedical, psychological, social and psychiatric status of the study group was carefully studied and

evaluated. Follow-up studies were conducted at five and 12-year intervals and the results are presented in this publication. Findings strongly indicate that while small declines in these areas can be expected normally with increasing age, severe deterioration is indicative of disease rather than aging. It is of importance to note that one of the significant factors associated with both mental and physical health in old age is continuing psychosocial activity and involvement and that this factor is strongly associated with longevity.

Since one of the most important bench marks of aging in our society is the retirement from work, studies have also been supported in this area. One study, conducted by Harvard University, has resulted in a document dealing with patterns of successful retirement and with variables predictive of successful adjustment to retirement. This document is presently being prepared for publication and distribution by the Institute. Another study is dealing with congruities and conflicts which exist between older and younger generations coping patterns and the study of values of each of three generations. Results indicate that age appears to be the strongest predictor of values.

2. EFFECTS OF STRESS

The NIMH believes the study of the effects of stress to be of particular import in view of the Institute's concerns about the utilization of coping mechanisms in the sustaining of mental health throughout the life span. The inability to handle stressful life situations can result in depression, suicidal attempts, and physical and mental illness. During the aging process many losses are sustained by the individual both physically and in important psychosocial relationships. It is crucial to understand the effects of these stresses in order to prevent later mental breakdown. One investigator is exploring how individuals draw upon their own experience and cope with difficulties over their life course and thereby sustain their mental health. Two other studies are following up groups of people, who were originally studied in the early forties, to learn what has taken place with the same group of people over the period in terms of their mental health and their relationship to their environment. One of these studies is in a densely populated urban center and the other in a rural area. Still another project is analyzing longitudinal epidemiological data from a community health research program which has surveyed the life events of the subjects and will relate them to various mental and physical health variables. One completed study examined the late results of excessive long lasting stress to which Norwegians who were in Nazi concentration camps were subjected. A morbidity study was carried out which compared the ex-prisoners to a control group. It was found that the ex-prisoners had less stable work lives, more changes of residence, more and longer sick periods, and longer lasting hospitalizations than the control group. Compared with the mortality of Norwegian population, that of the ex-prisoners was much higher. The investigator found he had to focus on total change in the individual's personality as a result of his traumatic experiences rather than on a single change. The ex-prisoners change in their reactions and their powers of resistance as a result of their earlier experiences.

3. HOUSING

The NIMH has pioneered in stimulating and supporting studies of the role that housing plays in the lives of older persons. Projects conducted by investigators at the University of California at Los Angeles have delineated the wide range of housing facilities in which older persons live and have evaluated the role that appropriate housing plays in adjustment to later life. These studies indicate nearly the total sample surveyed disapproved of retired persons living in the same household as their children. One project is evaluating the long-range effects of a new form of housing called "intermediate housing" at the Philadelphia Geriatric Center. This type of housing was developed through converting existing small row houses to low cost, private efficiency apartments. The residents consist of aged persons who were living in the community and who requested a social agency's help in relocating because of unsatisfactory living arrangements. This innovative housing came to the attention of the Senate Subcommittee on Housing for the Elderly of the Senate Special Committee on Aging. It was found to be so impressive that Bill S.2181 was introduced in the U.S. Senate in July 1973 to amend the National Housing Act to provide further assistance to private nonprofit corporations for conversion of existing single family housing for occupancy by elderly persons of low and/or moderate income.

4. SERVICES

The problem of providing appropriate and adequate services to the aging clients in the community needing them has long been a source of concern. One such study being carried out by the Family Service Association of America is examining and evaluating the consultation process as to its effectiveness in enhancing services to the aging in a number of its member agencies throughout the U.S.A. Another project is trying out a new mental health model to deliver services to the mentally frail elderly in an urban community. This project is based in a coffee house social center from which base extend outreach services, with backup from a hospital and follow-up social services where indicated.

5. MENTAL ILLNESS AND TREATMENT

The complexity of properly diagnosing psychiatric illness in older persons and in distinguishing between the various conditions from which they suffer is underlined by a study of differences in diagnostic processes between the United States and the United Kingdom being conducted by the New York State Psychiatric Institute. This study, which has been going on for several years, is now focusing on geriatric patients with special reference to distinction between and prognosis for organic and affective disorders. It is of interest that nearly 80 percent of the first admissions 65 years of age and over in the United States are diagnosed as organic disorders, while in the United Kingdom only 46 percent of admissions in this age group are so diagnosed. The complex relationship between these two conditions is such that one can mask the other, and means for more careful and precise differential diagnosis are badly needed.

Several other projects are concerned with the treatment of the mentally ill aged by various therapeutic means. One study has examined the utilization of Gerovital H-3, a Rumanian preparation of procaine hydrochloride, for depressed senile arteriosclerotic patients. Another is studying the use of anti-psychotic compounds in a group of agitated geriatric patients in a nursing home and also is examining the relationship between age and side effects of various drugs. Another investigator is testing the utilization of hyperbaric oxygen for improving the cognitive ability of senile persons which has aroused wide public interest. One study is assessing the effectiveness of specific therapeutic methods to mitigate maladjustment in the aging. Four different modalities are included in the study: drugs, psychoanalysis, theme oriented group therapy, and a counseling group.

6. COMMUNITY HIGH RISK ELDERLY

A particularly high risk group of elderly is found living in extremely deprived social economic conditions in our large cities. Among these persons are some who have been discharged from State mental hospitals. As a result, many disabled older persons are found living in a variety of congregate facilities in the community, including welfare hotels, apartment houses, and boarding houses. In many large cities a crucial problem has arisen because of large numbers of older persons living in run-down, single room occupancy hotels. One NIMH-supported study conducted by Roosevelt Hospital in New York City addressed itself to this problem. In this project the effectiveness of a comprehensive on-site treatment program on the social, psychological, and physical health of aged tenants in a hotel was studied. The principles of community organization were applied in organizing the tenants of the hotel to form a council to deal more effectively with the management and to consider the problems experienced by the residents, and various social, psychological, and medical services were provided through the hospital. The average age of the residents was 59, and approximately 87 percent received welfare funds. This project provides a model of an alternative manner of providing mental health services to an extremely isolated and dependent portion of the older population.

Another study is with a population of non-welfare aged poor who are living in a low price hotel on fixed incomes of social security or other retirement pension. This is a population at risk which has placed a high value on self reliance and does not use the formal agencies available. These types of hotels appear to have an informal social structure which provides the residents with supports. This research may answer how local services can be delivered to a marginally subsistent group setting which can reinforce their self and group reliance. Hotels of this type are sometimes in the way of urban renewal projects and are torn down leaving this group in great jeopardy from the loss of these supports.

7. INSTITUTIONS

The intricate manner in which the older person interacts with his environment is a complex problem of special importance to institutions for the aged. This importance is underlined by the fact that the great majority of the residents of such institutions display a significant degree of mental impairment resulting from organic brain disease. For the most part, the attitude toward this group has been one of pessimism in which rapid deterioration was seen as inevitable, intensive nursing care and supervision were required, and the patient was not permitted to participate in the decisions affecting him or even to care for his own personal wants.

At the Hebrew Home for the Aged in Riverdale, New York, it was found that even severely impaired older persons could participate in and receive therapeutic support by working in a workshop where they received actual wages supplied by performing tasks subcontracted from various industries. Also, as a result of this project a manuscript was produced which was published in 1974, on the training of nursing home staff to work with mentally impaired aged residents. A project at the Philadelphia Geriatric Center has demonstrated that deterioration can be retarded and that functioning may be maintained in older persons displaying a significant degree of mental impairment by individualizing treatment for such persons on the basis of their own needs as individuals. The principles emanating from projects such as these should have wide application in a variety of settings, and such applications need to be undertaken and evaluated.

A Social Work Guide for Long-Term Care Facilities, carried out under an NIMH contract, was published in 1974. The area of social services in these institutions had not previously been clarified, and this publication enhances the knowledge of administrators of long-term care facilities, social workers, and others as to utilization of social workers, as well as giving basic and important information on long-term care facilities . It has received considerable acclaim and was reprinted by the Government Printing Office.

The shortage of trained mental health personnel that exists generally is reflected in its most extreme degree by the relatively small number of mental health professionals concerned with the care of the elderly. Those who work in this field have generally been accorded very low status professionally and little has been done to interest students in the mental health disciplines in the problems of the older person or to prepare them to work with this age group. An effort is being made by NIMH to stimulate greater interest on the part of mental health training programs in providing suitable education and experience in working with older persons.

8. TRAINING

One training program is focused on staff employed in long-term care facilities and was inaugurated in 1971. The NIMH program, one of a number in DHEW, is designed to improve skills and increase knowledge of nursing home personnel in the mental health aspects of long-term care with special concerns for meeting

the needs of former mental hospital patients now residents of such institutions.

A continuing education project at the University of Southern California is providing training in aging for a multidisciplinary group of professionals, including general practitioners, psychologists, psychiatrists, city planners, and architects to increase their competence in dealing with mental health problems of the aged by informing them of current research findings. Training is provided through a summer institute in the Gerontology Center. The program has attracted large numbers of individuals and is generally considered a successful and outstanding program.

The training and use of paraprofessionals for work with the elderly is an important development that has taken place over the last few years. At Case Western Reserve University an experimental training project educated inner-city people for a new paraprofessional role created to meet a variety of needs of a noninstitutionalized elderly population. In a combination of classroom education and agency field experience, enrollees learned how to assist the elderly in their homes so they could maintain themselves and function at a maximum level outside institutions. This project had double value in that it provided an effective means of help to impaired older individuals as well as providing gainful and rewarding employment to individuals who might otherwise be unemployed.

The growing national concern with the problems of older Americans is evidenced by the convening of the White House Conference on Aging, the activities of the Special Committee on Aging of the U.S.Senate, the amount of legislation introduced in the Congress, and the numerous articles and programs on aging that have been forthcoming from newspapers, television, and other media.

The aged are sometimes described as if they were a homogenous group which would lead us to believing that one solution can be found for all mental health problems of the aged, but they are heterogeneous and, as in any other age group, suffer from a variety of mental health problems.

The Institute attempts to recognize these needs through its research and training programs.

D. HEALTH RESOURCES ADMINISTRATION

1. NATIONAL CENTER FOR HEALTH STATISTICS

All health statistics prepared by the National Center for Health Statistics (NCHS) can be presented in terms of specific age groups. These have been summarized for the aged in a report "Health in the Later Years of Life."

Measures of morbidity among the noninstitutional population include the incidence of acute conditions and injuries, number of days of disability, prevalence of chronic conditions, and the number of persons whose activities are limited due to chronic conditions. The latter category is the measure of health status which increases most rapidly among the elderly.

These data from the household Health Interview Survey are usually presented for the broad age groups 45-64 and 65 and older so that some other characteristics which are related to both age and health can also be shown: family income, educational attainment, and living arrangements. Also reported in the interview survey are number of visits to physicians, medical specialists and dentists, episodes of hospitalization, days of hospitalization, expenditures for various types of health services, and sources of payment.

Health Interview Survey reports published in 1972 and which emphasize the aging are "Age Patterns in Medical Care, Illness, and Disability," "Home Care for Persons 55 Years and Over," and "Convalescence at Home Following Hospitalization Among Persons 55 Years of Age and Older."

The Health Examination Survey of smaller national samples of the noninstitutional population yields high quality diagnostic data on some of the chronic diseases most prevalent among older people--specific types of heart disease, hypertension, arthritis, visual and hearing defects, and dental conditions. It also provides data on several physiological characteristics (height and weight, serum cholesterol level, blood glucose level, blood pressure) and on symptoms of psychological distress. In addition, current examinations include assessment of nutritional status. In this Health and Nutrition Examination Survey, the aging have been over-sampled to insure reliable statistics.

Separate surveys are made of the residents and patients in both long- and short-term care institutions--chronic disease hospitals, nursing homes, and general hospitals. These surveys provide data, classified by age and other characteristics, on utilization, diagnosis, medical and nursing care received and costs. "Charges for Care in Nursing Homes" (1972), a report from a recent Nursing Home Survey, includes data on coverage by Medicare and other types of medical assistance payments. Also published in 1972 and from the same survey were reports on "Employees in Nursing Homes" and "Services and Activities Offered to Nursing Home Residents."

The National Center for Health Statistics completed data collection and processing for the first national survey of 2000 nursing homes in December 1974. This survey provides data on the operating costs of the homes and on the characteristics of employees on their staffs. In addition, data was collected on approximately 20,000 resident patients in these homes. These data include sociodemographic characteristics, mental status, health status, assistance needed in performing activities for daily living, diagnoses, medical history and last examination, charges and source of payment, and any discharge plans. Release of preliminary data from this survey will be made in June-July 1975. Plans are now underway for the second National Nursing Home Survey which is being expanded to include data on discharged residents, changes in facility characteristics, and residents' health status.

The National Center for Health Statistics also produces the national and State life tables and data on causes of death by demographic characteristics and geographic distributions of the population.

2. DIVISION OF FACILITIES UTILIZATION, BUREAU OF HEALTH RESOURCES DEVELOPMENT

A primary objective of the Division of Facilities Utilization (Hill-Burton program) is to stimulate the modernization and construction of facilities needed to buildup an efficient, well-coordinated network of services for the acute care, ambulatory care, long-term care, and rehabilitation of all persons, including the aged and aging. Since the enactment of the Hill-Burton program, the service has provided assistance for the modernization and construction of 102,300 long-term care beds in chronic disease hospitals, nursing homes, and units of general hospitals.

The need for modernization and construction of long-term care facilities continues at a high level. As the aging population continues to increase, the demand for adequate nursing home care for them must be met. In addition, the enactment of the Medicare, Medicaid and other programs partially removed the economic barriers to care of the aged. State agencies report that 355,000 long-term care beds, including extended care facility beds, need to be modernized or added.

P.L. 93-641, signed on January 4, 1975, extended and extensively revised the Hill-Burton Program. Long-term care facilities will no longer be aided as a separate formula grant category. However, they will be eligible under two types of formula grant assistance: (1) modernization of health facilities, and (2) construction of new inpatient medical facilities in areas which have experienced recent rapid population growth. The same facilities are also eligible for loans or loan guarantees with interest subsidy. A third type of grant assistance is project grants for construction and modernization projects designed to prevent or eliminate safety hazards in medical facilities or to avoid noncompliance by such facilities with licensure or accreditation standards. The FY 1976 Budget requests $22 million for project grants, $78 million for formula grants (25 percent or more must be used for outpatient facilities), and nothing for new loan authority.

In addition, the following services provided by the Division of Facilities Utilization contribute to improved health care of the aged and others throughout the Nation: (1) technical and professional consultation regarding all aspects of facility functional planning, design, maintenance, and construction, which is available to all public agencies, and nonprofit organizations; and (2) guide material relating to the planning, design, equipping, and construction of health facilities, which is continually being developed and distributed.

3. NATIONAL CENTER FOR HEALTH SERVICES RESEARCH

The Division of Long-Term Care, National Center for Health Services Research, was delegated prime responsibility for long-term care and aging, with the dual functions of research and development in long-term care and aging, and provider improvement activities designed to improve the quality of care in long-term care institutions by upgrading the performance of long-term care personnel through short-term training programs.

Research and development emphasis is placed on: (1) measuring the quality of care, including the development of instruments to insure that the most appropriate level of care is being provided; (2) offering consumers and the public mechanisms to insure a greater and more knowledgeable voice in demanding quality of care and increased options for care; and (3) improving coordinating mechanisms for increasing the options of patients for receiving needed care in the appropriate setting through a balanced array of institutional, ambulatory and home health services, including improved administration and management procedures.

Specific areas of concentration include: intensified activity in relation to implementation of Section 222 of Public Law 92-603 in developing demonstrations to determine cost-effectiveness of day care, homemaker service and intermediate care; further development and testing of mechanisms and instruments for patient assessment to improve decision-making regarding placement, continuity and appropriateness of care, and assessment for the quality of care being provided; development of a cost data reporting system for nursing homes; analysis of the usefulness of data to government and non-government providers; exporting a uniform basic data set for long-term care to States in Region V; evaluation of the feasibility and impact on quality of the regulatory use of indices of quality of care in nursing homes; assessment of the cost effectiveness of alternative methods of care; and planning and developmental activities necessary to research the outcomes of nursing home care (length of institutional stay, mortality rate, place to which discharged, change in functional status, change in mental status, and consumer satisfaction) as they relate to such variables as staffing patterns, costs, employee and administrator attitudes, environmental and structural variables and ownership-control status.

Responsibility for directing Federal resources toward short-term training of personnel employed in long-term care facilities continues in the Division of Long-Term Care. Since the inception of provider training activities with the Administration's Nursing Home Initiatives of 1971, there has been continual growth of training opportunities through a variety of strategies. The number of training opportunities supported has reached approximately 78,000 professional and para-professional long-term health care personnel as of December 31, 1974.

In 1974, to further the Department's efforts toward upgrading the quality of care in the Nation's nursing homes by improving the skills of those responsible for providing that care, 16 training contracts were awarded or continued including: four statewide training programs for the instruction of nurse aides; three contracts with national organizations (American Medical Association, American Dietetic Association, American Medical Record Association); the continuing of the six Regional Training Centers initiated in 1973; and the initiation of three additional centers. A contract to develop a Media Center to serve as a source of published material, audiovisual aids, training curricula and research documents related to gerontology as well as to the health, environmental and psychosocial aspects of long-term care, and a contract to evaluate the entire training effort were also awarded.

IV. SOCIAL AND REHABILITATION SERVICE

A. ASSISTANCE PAYMENTS ADMINISTRATION

Under the maintenance assistance programs, cash payments are made to needy persons for the cost of food, shelter, clothing and other necessary items of daily living.

P.L. 92-603, enacted October 30, 1972, established a national program to provide supplemental security income to individuals who have attained age 65 or are blind or disabled. The national program became effective as of January 1, 1974, since which time the Social Security Administration has been responsible for making Federal payments to eligible recipients.

Prior to that date, the maintenance assistance program supporting aged persons was old age assistance. Additionally, there were some persons over age 65 who were recipients under the aid to the blind and aid to the permanently and totally disabled programs, plus aged persons in the aid to families with dependent children program. Since January 1, 1974, these programs have continued in effect in Guam, Puerto Rico, and the Virgin Islands, and the Assistance Payments Administration retains responsibility for administering them in these areas.

The number of aged persons and the total Federal share of cash payments for maintenance assistance programs affecting the aged are shown in Table 1 below for fiscal years 1972 through 1976.

Table 1.--Number of aged and Federal share of payments

Fiscal Year	Number of Recipients	($ in thousands) Federal Payments	($ in thousands) Administrative Costs	Average Annual Payment Rate Per Recipient
72 Actual	2,098,967	$1,217,401	$80,118	$580.00
73 Actual	2,034,689	1,187,961	99,791	583.80
74 Actual 1/	1,959,670	575,427	59,982	576.01
75 Estimate 2/	75,163	22,055	3,652	385.83
76 Estimate 2/	23,500	3,150	520	111.70

1/ Includes one half-year payments and costs for programs affected by P.L. 92-603.

2/ Adult programs in Guam, Puerto Rico, and Virgin Islands only.

B. COMMUNITY SERVICES ADMINISTRATION

The Community Services Administration has responsibility for administering the Social Services program authorized by Titles I, IV-A, VI, X, XI, XIV and XVI of the Social Security Act, as amended in 1972.

The 1974 Social Services Amendments to the Social Security Act (P.L. 93-647) establishes a new Title XX which authorizes grants to States for services to eligible individuals based on income. Except for the Commonwealth of Puerto Rico, the Virgin Islands and Guam, Title XX supersedes all of the authorizing Titles cited above and is effective October 1, 1975.

A broad spectrum of services directed at assisting needy aged persons to attain or maintain the maximum level for self-care and independence for which they have potential is provided through this program. These include such services as day care, foster care, protective services, health related services, homemaker, chore, transportation and other services that assist elderly persons to remain in their own homes or in community living. Services are also offered which facilitate the entry into institutional care where needed and to help the individual move out of institutional care when possible. In FY 1976 it is expected that States will expend $334,000,000 Federal dollars under this program on services to the aged.

(Dollars in Thousands)

	1972 Actual	1973 Actual	1974 Estimate	1975 Estimate	1976 Estimate
Social Services.....	$170,000	$216,000	$231,000	$306,000	$334,000

C. MEDICAL SERVICES ADMINISTRATION

Title XIX, known as Medicaid, provides Federal matching payments for State expenditures for health care for the poor. In FY 1974, fifty-three States and jurisdictions were participating in Medicaid (Arizona is the only State not participating; however, Arizona plans to begin its Medicaid program on October 1, 1975).

With the federalization of the adult categories on January 1, 1974, under the Supplementary Security Income (SSI) program, States are not in all cases required to provide Medicaid to all adult recipients of cash assistance under Title XVI, as was the case in the past under Titles I, X, XIV, or XVI. Limited Medicaid coverage of SSI cash assistance recipients will apply in States which, in determining Medicaid eligibility, opt to apply any eligibility criteria from the January 1, 1972, medical assistance standard which is more restrictive than the eligibility requirements for the Federal Title XVI program for aged, blind, and disabled individuals. States which retain any eligibility factor(s) from their January 1, 1972, standard which is (are) more restrictive than the Title XVI eligibility factor(s) must deduct a person's medical expenses from his income in determining eligibility. (They are not required to cover Title XVI cash assistance recipients who have higher income or resources, or who otherwise do not meet the January 1972, medical assistance standard.) As of January 1, 1974, seventeen States planned to resteict Medicaid eligibility of SSI recipients under this option.

Thirty-six States extend Medicaid coverage to all recipients of cash assistance under the SSI program. States also have the option of providing Medicaid coverage to persons receiving a State Supplemental payment, subject to certain limitations. In addition, States may still elect to cover certain medically needy persons who are eligible for help only with their medical bills and who do not receive maintenance payments.

States are required to provide in their Title XIX program: inpatient hospital care, outpatient care, skilled nursing home care for individuals 21 and over, early and periodic screening, diagnosis and treatment services for children under 21, family planning, physicians services, lab and X-ray services and home health services, as well as, by regulation, transportation to medical care where needed. Use of skilled nursing home services, particularly, is primarily by the aged. In addition, States may cover optional services, many of which are of particular concern to the elderly; for example, 49 offer prescribed druga, 40 cover eyeglasses, 34 finance physical therapy, and 41 pay for prosthetic devices. Additionally, Title XIX in FY 1974 contained several provisions directed solely to those over 65: payment of Medicare premium, copayment and deductible amounts (for cash assistance recipients), and coverage of inpatient hospital services in institutions for mental diseases.

The aged account for a significant portion of Medicaid expenditures. About 40 percent of the $10.6 billion Federal, State and local program dollars was spent on care for the aged in FY 74, and it is estimated that 4 million people over age 65 received Medicaid services. For most of these persons, Medicaid was providing services which supplemented and complemented those provided by Medicare.

In FY 1974, the Medical Services Administration continued its activities in developing alternatives to institutional care. Staff are providing consultative assistance to projects testing day care and day hospital services as well as evaluating the team concept of assessment and care.

(Dollars in Thousands)

	1972	1973	1974	1975	1976
Total, Medical Assistance	$1,778,348	$1,539,398	$2,247,541	$2,647,945	$3,059,787

D. SRS OFFICE OF PLANNING, RESEARCH, AND EVALUATION

No SRS programs are targeted on the aged population per se, but elderly persons make up a large percentage of the client population in the Medicaid and Social Services programs, particularly in the long-term care area. The evaluation and research activities of SRS, therefore, consider the aged as a significant subgroup of the client population.

The current evaluation activity most significant for the elderly is a project funded jointly with the Administration on Aging and the Health Resources Administration. This project focuses on de-institutionalization and the question of what is appropriate care for impaired persons.

Emphasis is on development and testing of the methodologies necessary for a nation-wide longitudinal survey, including a functional classification system for adult persons requiring long-term care, a comprehensive set of LTC service packages and settings, and a costing methodology. A major field-test of the functional classification system and survey instrument is to be completed soon and development of the service package and costing methodologies is continuing. Discussions have begun with other units of the Department to determine more precisely the target population and the best means of obtaining a longitudinal sample representative of the entire LTC universe (both institutionalized and non-institutionalized). The nation-wide survey, which will of necessity be a Department-wide effort, will be funded no earlier than FY 76.

Another evaluation effort will provide information about the effects of SRS programs on target population which include the elderly. This is a study of the "spend-down" provision of the Medicaid program which will obtain data on socio-demographic and economic characteristics of persons who entered the Medicaid program through the spend-down mechanism, including the effects of the spend-down on their income and assets, and the health service requirements which caused them to enter the program.

The Office of Research and Demonstration within SRS has created a separate and identifiable unit in the Health Services Division to focus on long-term care. Analysis of long-term care financing, developing alternatives to institutionalization, and studying the impact upon health care delivery systems is being emphasized.

Although the long-term care R&D program is primarily concerned with the delivery of health care services to the chronically ill and disabled of all age groups, the elderly comprise the highest proportion of the population in need of these services. Two major projects exploring the improvement of service delivery for long-term care recipients have been initiated. The first project, the Utah Long-Term Care Payments System, is a State-wide experiment designed to link reasonable cost-reimbursement with the quality care within skilled nursing facilities.

The second project is primarily concerned with exploring the viability and cost-effectiveness of delivery services to the chronically ill and disabled in various types of community settings. Promoting community care alternatives to institutionalization for the chronically ill and disabled interested in and able to function outside of institutions can have an important effect upon the lives of the elderly. The project, "The Feasibility and Cost-Effectiveness of Alternative

Long-Term Care Settings," a study being undertaken by Stanford Research Institute, is investigating long-term care service delivery programs outside of nursing homes, day care centers and long-term hospitals. A companion investigation of day care centers is being undertaken by the Health Resources Administration. When completed, the SRI project will provide extended systematic information on studies of alternative long-term care settings; provide a number of case studies with guidelines on initiating similar programs useful to innovators developing community care programs; form a base for identifying cost-finding methods for comparing cost in different settings; and provide policy and program change recommendations emerging from the study of the effects of legislative, regulatory, or administrative programs on the feasibility of establishing, and the viability of operating such programs.

Current plans for research and demonstration projects include the initiation and analysis of community-wide coordinated health and social service delivery programs; the analysis of prospects for developing a system of cost classification for long-term care service delivery programs independent of particular settings; and the development of analytical tools for appraising the response of the chronically ill and disabled to alternative possibilities for long-term care services.

The demonstration projects program in public assistance under Section 1115 of the Social Security Act provides grants for several projects which are totally or partially concerned with providing a variety of services to elderly recipients in public welfare. These projects are carried out under the auspices of State public welfare agencies.

A project in Pennsylvania on health services is demonstrating how such services should be administered to persons 65 years or older who were victims of a flood disaster.

In Connecticut, California, Texas and Wisconsin, projects are demonstrating the effect of social services including day care and homemaker to keep the elderly in their own homes instead of in intermediate care facilities and nursing homes.

Housing allowances are being made to the elderly in eight experiments which are being carried out by the Department of Housing and Urban Development. Waiver of plan requirements have been granted by the Secretary to enable SSI recipients to participate in the experiments without having their grant entitlement reduced.

A project in Michigan is working to integrate public health general hospital community outreach and social services in a practical manner in cooperation with the Inkster Comprehensive Service Project for the aging.

In Utah methodology for a reimbursement system is being developed which should reasonably relate the cost of skilled nursing homes and intermediate care facilities.

Other projects involve aged welfare recipients in pre-paid health insurance plans, health maintenance organizations, and integrated services delivery centers also involve aged welfare recipients.

(Dollars in Thousands)

	1972	1973	1974	est. 1975	est. 1976
Section 1115 Demonstrations	280	125	138	850	5,000
Section 1110 Research and Evaluation*	-	-	-	763	300

* Not reported in 1972-1974

V. OFFICE OF EDUCATION

1. LIBRARY RESOURCES

The Division of Library Programs, under the provisions of Title I of the Library Services and Construction Act, provides information and advice on programs oriented to the aging which are administered by State Library agencies; assists training institutions through programs designed to give librarians skills required to meet the special library needs of older persons; maintains liaison with other Federal, State, and local agencies and organizations concerned with the aging; and assists in conferences of professional and lay leaders interested in library-sponsored activities for older people.

Older Americans account for well over half of the almost 400,000 readers of talking books on discs and cassette tapes, braille books and periodicals, and other special materials available free for those unable to use conventional print materials because of physical disability. LSCA funds continue to be utilized in programs to identify eligible readers; publicize available services, purchase materials and reading aids; underwrite programs for taping materials in Spanish, Indian and other non-English languages as well as in English; and provide staff and equipment in regional and sub-regional libraries for the blind and physically handicapped.

Library services especially tailored for the Aging fall into two general categories: those which are provided for the elderly population in institutions; and those which reach out to the elderly in the community.

Since 1967, LSCA has furnished funds for the purpose of establishing and improving library service in institutions operated or substantially supported by a State. The many aged persons residing in State institutions are among the beneficiaries of this program which provides multi-media materials with comfortable, attractive reading, listening and film-viewing facilities. Such libraries offer a variety of programs which may include facilities. Such libraries offer a variety of programs which may include films, music, poetry reading, storytelling, book talk, discussions and games.

To isolated, elderly persons who are housebound and to those immobilized in nursing homes, the librarian brings selected materials for reading, viewing, and listening as well as a personal link with the library. In Florida, the Manatee County Library System reaches out to the housebound and to the residents of five nursing homes with Project Score (Senior Citizen-Oriented Reading Effort) with personal visits and the loan of large print books, recordings, and framed color prints. In one year, one staff member recorded 899 visits in this project.

In Boone, Iowa, the Erikson Public Library planned a program and named it "Old Settler's Library," for 2500 senior citizens living in the oldest section of the city together with 1800 people receiving public assistance. A rented store front building has become a library center with a special array of print and non-print materials, including cassettes and magazines in large print. It is also used as a senior citizen center, for meetings, socializing, and for assistance to those who want to study independently, gain high school equivalency accreditation, learn a craft, or train for a job, with the help of community college staff and volunteer groups. All age groups are welcomed by "Old Settler's Library," especially those users from the three homes for the aging in the neighborhood.

In 1974, isolated and rural as well as immobilized elderly persons benefited from the increase of books-by-mail programs, provided by libraries at no cost to the users who select their reading from mailed book catalogs.

It is estimated that approximately $600,000 will be used in fiscal year 1975 for projects involving the aging. In fiscal year 1976 Federal support for library services for the elderly will be decreased and it is anticipated that these services will be assumed by States and localities.

2. ADULT EDUCATION

In fiscal year 1974 approximately 80,000 persons 55 years of age and older were enrolled in adult education programs authorized under the Adult Education Act, as amended. This was approximately 8.34 percent of the total enrollment. It is expected that the participants age 55 and over in fiscal years 1975 and 1976 will be approximately the same number as in fiscal year 1974.

3. UNIVERSITY COMMUNITY SERVICE AND CONTINUING EDUCATION

Title I of the Higher Education Act of 1965 authorizes grants to the 50 States, the District of Columbia, Guam, American Samoa, the Commonwealth of Puerto Rico, and the Virgin Islands. The purpose of the program is to facilitate community problem solving through cooperation with postsecondary institutions. Each State administers the program by an agency designated by the Governor, under a State Plan approved by the U.S. Commissioner of Education. The State agency establishes program priorities and approves and funds institutional proposals. Funds are provided by a State formula with a 66-2/3 Federal and 33-1/3 non-Federal basis. Of the sums appropriated the Commissioner may reserve 10 percent for special project discretionary grants, and allot $25,000 each to Guam, American Samoa, Puerto Rico, and the Virgin Islands and $100,000 to each of the States and the District of Columbia. The remainder is distributed on a population ratio basis. Total appropriation for fiscal year 1974 was $14,250,000. No funds are requested for this program in fiscal year 1975.

The State-Grant Program has supported a number of projects designed to assist the older American. During 1974 an estimated 30,000 persons in 27 states participated in 41 such projects. Activities included training programs for professional and paraprofessional staff of nursing homes; preretirement and retirement counseling; consumer education; and informational programs regarding Medicare/Medicaid benefits and housing assistance.

Special Projects, authorized by Section 106, permits the Commissioner to reserve 10 percent of the sums appropriated to support special projects which are designed to seek solutions to "national and regional problems relating to technological and social changes and environmental pollution." Such special activities are limited to demonstration or experimental efforts. Projects must be based on a design for and the implementation of organized continuing education activity for adults.

In 1974, the first year of implementation, two special projects were supported. One project established a broadly based community consortium involving all levels of educational institutions to develop and demonstrate an In-Depth Pre-Retirement Education Program. The second project is exploring the effectiveness of different approaches to the Post-retirement Education of divergent groups. The participants represent a wide socioeconomic range as well as differing ethnic cultures and value orientations.

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