programs for the handicapped

Office of
Mental Retardation Coordination

March 23, 1972 72-3

On January 26, 1972, the Secretary of Health, Education, and Welfare directed the establishment of the Office of Mental Retardation Coordination. This new unit replaces the Secretary's Committee on Mental Retardation, and will be responsible for the duties formerly assumed by that Office.

Functions:

- Serves as a means of coordination and evaluation of the Department's mental retardation activities.
- Serves as a focal point for consideration of Department-wide policies, programs, procedures, activities and related matters relevant to mental retardation.
- Serves in an advisory capacity to the Secretary in regard to issues related to the administration of the Department's mental retardation programs.
- Serves as liaison for the Department with the President's Committee on Mental Retardation.

Location and Staff:

The Office is a unit of the Office of the Assistant Secretary for Community and Field Services. As such, it receives policy direction and supervision from Mrs. Patricia Reilly Hitt, Assistant Secretary for Community and Field Services. Mr. Wallace K. Babington serves as the Director.

OTHER ITEMS

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Office of Mental Retardation Coordination

Coordinating Committees:

Steering Committee: Consists of representatives of the Office of the Assistant Secretary for Health and Scientific Affairs, Social and Rehabilitation Service, Health Services and Mental Health Administration, National Institutes of Health, and Office of Education. This group will be responsible for advice and consultation in the implementation of the Office function as stated above.

Mental Retardation Interagency Committee: Consists of representatives of all mental retardation operating programs. Its functions will be to provide a means of communication, information exchange and program development for agency staff concerned with Federal mental retardation activities.

Regional Office:

The Secretary has directed that an interagency coordinating committee be established in each of the Department's Regional Offices. At the present time, the Regional Offices are served by a mental retardation coordinator located in the Office of the Regional Director. The new committee will be the responsibility of that staff member.

Public Information:

Publications formerly issued by the Secretary's Committee on Mental Retardation are now available from the Office of Mental Retardation Coordination, U. S. Department of Health, Education, and Welfare, Washington, D. C. 20201. All inquiries should be directed to that office.

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I. INTRODUCTION

Since 1969, the Division of Developmental Disabilities, Rehabilitation Services Administration, has been responsible for collecting and publishing data on the institutionalized mentally retarded persons in the United States. These data are extremely useful in planning for facilities and services, research and training, and legislation and financing. In an effort to provide current data, the provisional survey statistics tabulated in current Facility Reports are collected and published annually for certain patient movement and administrative categories by State for the Public Institutions for the Mentally Retarded (referred to as "Institutions" in this report).

Trends in certain patient movement categories for institutions which are depicted graphically for the years 1950-1970 are indicated numerically for the years 1963-1970 in Table 1, and include estimates for under-reporting wherever possible. These totals which are the most complete available, supersede totals published in prior reports. Also shown in Table 1 are the same data expressed in index numbers with 1963 used as the base year. Thus, percent change since

the base period can be read directly from Table 1, with increase being numbers greater than 100. For instance, the 1964 index number for admissions is 102.5. This means that admissions in that year were 2.5 percent greater than base period admissions. An index number shows the percent change between a specific year and the base period. It does not indicate percent change between a specific year and the base period. It does not indicate percent change between years other than the base year. Table 2 shows detailed patient movement and administrative data for each State. Definitions of terms used in this report are given in Section III.

II. HIGHLIGHTS

For the third consecutive year the number of resident patients in the Public Institutions for the Mentally Retarded decreased. This decrease of approximately 2500 residents was slightly less than that evidenced in 1969 and lowers the number to pre-1965 levels. As in the previous year this decrease was associated with an increase in the number of resident facilities; from 180 to 140. At the end of FY 1970 there were 186,743 resident patients in these institutions.

The annual number of total admissions over the years has fluctuated between 13 and 17 thousand. In 1970, there were 14,985 total admissions, which is approximately equal to the 1969 figure. This resulted in a rate of 7.5 per 100,000 population which indicates no change from the 1968-1969 rate.

The number of net releases showed the same marked increase in 1970 as the preceding year over the generally moderate year by year increase during the 60's with the exception of 1965, a year in which there was a large increase in total admissions. In 1970, there were 14,702 net releases which equaled 1969 and represents an increase of about 26 percent over the 1968 figure. The rate per 1,000 average resident patients was 78.0 as opposed to 60.5 in 1968.

The annual number of deaths in institutions has remained fairly constant since 1958, as has the death rate per 1,000 average resident patients. This rate has been about 19 for each of the last ten years, except for 1958, when the rate rose to 23 per 1,000 average resident patients.

There are now 117,000 full-time personnel caring for the mentally retarded in these institutions. The ratio of resident patients to personnel has consistently reflected more personnel per patient over the years, and in 1970, as in the previous three years, there were less than two resident patients for each full-time employee. In 1960, this ratio was three to one.

The maintenance expenditures for the care of patients have also greatly increased. The figure of approximately $871,000,000 in 1970 is more than three times the amount spent in 1960. Converting these data into ratios, $11.64 was spent each day per patient under treatment in 1970, as compared with $4.25 in 1960, a 174 percent increase over this period.

III. DESCRIPTION AND LIMITATIONS OF THE DATA

A. Patient Movement Data

The summary data presented in this report may be used to analyze the annual changes in year end populations of the Public Institutions in terms of three categories of patient movement (admissions, net releases, and deaths). These categories are defined as follows:

1. Admissions: This category includes first and readmissions. First Admissions are all patients admitted to a public institution for the mentally retarded without a record of previous care, i.e., a record of an admission and a formal discharge, in either a public or private institution anywhere. Thus, a patient coming into a public institution for the mentally retarded from a hospital for mental disease would be considered a first admission. Readmissions are all patients admitted with a record of previous care in a public or private institution.

2. Net Releases Alive from Institution: The concept of "net release alive from Institution" takes into account movement of patients into and out of the Institution since this quantity is the number of placements on extramural care plus direct discharge from the Institution less the number of returns from extramural care, all occurring during any one year. National data on placements and returns from extramural care are not available but net releases may be computed from less detailed movement data as:

Net Releases Alive from Institution	=	Resident Patients Beginning of Year	+	All Admissions Excluding Transfers	-	Deaths in Institution	-	Resident Patients End of Year

Interpretation of net releases alive from Institution should be made with caution. This quantity is the net number of releases alive from the Public Institutions in the State system and includes not only direct discharges to the community and placement on leave but also direct discharges to other inpatient facilities outside the State system such as public mental hospitals, boarding care homes, and public institutions in other States. The number of net releases is used as a measure of movement out of the Institution rather than the total number of discharges because many discharges occur while patients are already outside the Institution on extramural care. The number of net releases may be considered an estimate of the number of effective releases from the Institution under the assumption that subtracting returns from leave during the year removes only the short term visits, leaves, and escapes and retains the effective releases; i.e., those from which the patients did not return to the Institution within the time period covered.

3. Deaths in Institution: This category includes only deaths occurring to patients resident in the Institution and does not include deaths among patients on leave, even though these patients are still on the Institution books.

4. Patient Movement Ratios per 100,000 Civilian Population: The admission ratio measures the proportion of people coming under care during the year while the resident patient at end of year ratio measures the proportion of the population under care at one point in time.

5. Patient Movement Ratios per 1,000 Average Resident Patients: These ratios relate each of three movement categories: Total Admissions, Net Releases, and Deaths, to the average resident population, thus providing indexes of the amount and type of patient movement activity that occurred during the year. It should be kept in mind that the ratios shown in this publication are based on totals and as such they have the limitations of totals. They are not standardized for such important variables as age, sex, medical classification, and years in the Institution. To illustrate how these ratios are descriptive of changes in resident patient populations, consider the following hypothetical examples:

Suppose that the resident patient populations in State A and State B each increased by three percent (or 30 per 1,000). Considering only these data gives a limited and potentially misleading view of patient movement activity. However, now suppose that the patient movement ratios are computed to be the following:

Movement Category	State A	State B
Admissions	99.3	162.7
Net Releases	79.9	144.0
Deaths	16.3	15.7

These ratios show that State B has much higher rates of patient movement into and out of the Institution than State A. While these ratios highlight areas of difference between the two States, conclusions based only on these ratios may be faccacious. The differences can be isolated further by analyzing the data in terms of the patient characteristics mentioned above (age, sex, and medical classification). Even at this point, one cannot evaluate the relative efficacy of the two public institutional programs since differences in patient movement ratios between States may also be attributable to a great many other factors, such as policies and laws controlling admissions and release, the ways in which the public institutions are utilized by the communities they serve, the types of patients admitted, the various treatment programs within the Institutions, and the availability of various community facilities that can serve as adjuncts or alternatives to institutionalization. Since the reasons for interstate differences in these movement ratios are complex and vary considerably from Institution to Institution within and between States, ratios constructed from gross movement data (i.e., State totals) cannot be used to measure the therapeutic effectiveness of various programs.

6. Ratio of Net Releases to 1,000 Admissions: The ratio "net releases per 1,000 admissions" is a convenient index for summarizing the live net movement into and out of the Institution. For example, if the ratio is less than 1,000 there were more admissions than net releases. Note that this index does not relate net releases to admissions in the sense of a percent or rate because not all releases during a year derive from the admissions during that year. Some of these net releases occurred to patients with lengths of stay greater than one year, that is, patients admitted during some prior year.

B. Expenditure Ratios

The expenditure per average daily resident patient has been the most commonly used ratio for comparing Institution expenditures. Its major limitation is that it does not adequately take into account the number of admissions for which a large share of the expenditure is required. If the patient base is enlarged to include admissions during the year, the resulting sum is the best available estimate of patients under treatment during the year. This quantity is actually defined as:

Patients under Treatment	=	Resident Patients Beginning of Year	+	All Admissions Excluding Transfers	+	Returns from Leave among Patients on Leave Beginning of Year

The estimate, however, does not include the last term since these data are not available nationally.

The ratio of expenditures to patients under treatment appears to be a more realistic measure, but it does not solve the problem completely. While a larger share of the expenditures is required for the care of admissions, the index weights both admissions and resident patients equally.

C. Interstate Variation

Considerable variation among the States in patient movement, personnel, and expenditure data is indicated in Table 2.

Actual numbers are not comparable among States since they do not take into account differences in size of population. Therefore, ratios have been computed for several data categories. For example, net releases and total admissions per 1,000 average resident patients show considerable variation, with net release rates ranging from 21 to 557. Rates of admission and resident patients at end of year per 100,000 civilian population also vary considerably from State to State. Considerable interstate variation is further illustrated by the range in expenditures per patient under treatment per day from a high of $16.38 (excluding Alaska) to a low of $4.61.

However, as has been emphasized in Sections A4-A6, comparison of State ratios, while serving to highlight areas of differences, are limited. More detailed classifications of movement categories by such variables as age, sex, medical classification and time on books are needed. Data on most of these variables as well as more detail on personnel and maintenance expenditures will be available in other publications. This detail will provide partial explanations of the gross differences noted in the tables. Also, as mentioned previously, other factors such as policies and laws affecting admission and releases of patients, other community treatment facilities, effectiveness of therapeutic programs, etc., must be evaluated to determine the extent of their influence on interstate variation.

TABLE 1

RECENT TRENDS OF PATIENT MOVEMENT AND ADMINISTRATIVE DATA, PUBLIC INSTITUTIONS FOR THE MENTALLY RETARDED
UNITED STATES, 1963 - 1970*

Item	1963	1964	1965	1966	1967	1968	1969	1970
All Admissions	14,909	15,276	17,300	14,998	15,714	14,688	14,868	14,985
Net Releases	8,156	9,292	7,993	9,268	11,665	11,675	14,701	14,702
Deaths in Institutions	3,498	3,384	3,583	3,601	3,635	3,614	3,621	3,496
Resident Patients End of Year	176,516	179,599	187,273	191,987	193,188	192,520	189,394	186,743
Personnel (full time) at End of Year	69,494	74,128	79,056	88,974	94,900	100,804	107,737	117,327
Maintenance Expenditures	$353,574,833	$396,588,263	$441,714,654	$505,141,941	$576,620,954	$672,735,697	$764,605,791	$870,889,825
Per Resident Patient								
Per Year	1,984.00	2,188.77	2,334.99	2,615.30	2,965.33	3,471.99	3,995.58	4,634.85
Per Day	5.44	5.98	6.40	7.17	8.12	9.49	10.95	12.70
Per Patient under Treatment								
Per Year	1,879.43	2,062.61	2,221.36	2,447.27	2,774.10	3,244.98	3,681.02	4,249.47
Per Day	5.15	5.64	6.09	6.70	7.60	8.87	10.08	11.64
				INDEX NUMBERS				
All Admissions	100.0	102.5	116.0	100.6	105.4	98.5	99.7	100.5
Net Releases	100.0	113.9	98.0	113.6	143.0	143.1	180.2	180.2
Deaths in Institutions	100.0	96.7	102.4	102.9	103.9	103.3	103.5	100.0
Resident Patients End of Year	100.0	101.7	106.1	108.8	109.4	109.1	107.3	105.8
Personnel (full time) at End of Year	100.0	106.7	113.8	128.0	136.6	145.1	155.0	168.7
Maintenance Expenditures	100.0	112.2	124.9	142.3	163.1	190.3	216.2	246.3
Per Resident Patient								
Per Year	100.0	110.3	117.7	131.8	149.5	175.0	201.4	233.6
Per Day	100.0	109.9	117.6	131.8	149.3	174.4	201.3	233.4
Per Patient under Treatment								
Per Year	100.0	109.7	118.2	130.2	147.6	172.7	195.9	226.1
Per Day	100.0	109.5	118.3	130.1	147.6	172.2	195.7	226.0

*These data include estimates for underreporting wherever possible.

TABLE 2
Provisional Patient Movement and Administrative Data: United States, FY 1970
Public Institutions for the Mentally Retarded
PERSONNEL AND FINANCIAL DATA

State	Average Daily Resident Patient Population	Patients under Treatment	Total Full-time Personnel End of Year	Maintenance Expenditures		
				Total	Daily Expenditures	
				Amount	Per Resident Patient 16/	Per Patient under Treatment 17/
United States 1/ ...	187,897	204,941	117,327	$870,889,825	$12.70	$11.64
Alabama 2/.....	2,202	2,393	756	5,560,945	6.92	6.37
Alaska	105	118	114	1,533,977	40.02	35.62
Arizona	918*	1,020	522	2,725,339	8.13	7.32
Arkansas 3/.....	1,018	1,467	1,012	4,742,051	12.76	8.86
California 4/.....	11,723	13,173	12,823	78,777,500	18.41	16.38
Colorado 5/.....	2,174	2,410	1,500	13,835,460	17.44	15.73
Connecticut	3,993	4,764	2,491	22,065,599	15.14	12.69
Delaware	574	603	430	2,593,522	12.38	11.78
District of Columbia ...	1,264	1,391	450*	6,000,000	13.00	11.82
Florida	5,898	6,546	4,139	25,686,530	11.93	10.75
Georgia 7/.....	1,769	2,056	1,819	11,947,433	18.50	15.92
Hawaii	747	817	408	3,532,003	12.95	11.84
Idaho	632	828	345	1,972,288*	8.55	6.53
Illinois	8,263	8,957	5,574	44,217,356	14.66	13.53
Indiana	3,811	3,929	2,597	17,336,943	12.46	12.09
Iowa	1,608	1,827	1,454	9,571,667	16.31	14.35
Kansas	1,959	2,317	1,752	12,906,002	18.05	15.26
Kentucky	1,021	1,213	694	4,313,997	11.58	9.74
Louisiana	2,874	3,206	2,200	12,706,850	12.11	10.86
Maine 9/.....	776	940	569	4,794,805	16.93	13.97
Maryland	3,123	3,485	1,914	14,473,570	12.70	11.38
Massachusetts	7,696	8,136	3,907	35,529,314	12.65	11.96
Michigan	12,059	12,636	6,378	58,444,131	13.28	12.67
Minnesota 10/.....	4,542	5,073	2,429	19,407,164	13.04	12.01
Mississippi	1,268	1,420	498	2,391,279	5.17	4.61

TABLE 2 (CONTD.)

PERSONNEL AND FINANCIAL DATA

State	Average Daily Resident Patient Population	Patients under Treatment	Total Full-time Personnel End of Year	Maintenance Expenditures		
				Total	Daily Expenditures	
					Per Resident Patient 16/	Per Patient under Treatment 17/
				Amount		
Missouri 11/.....	2,534	4,038	2,233	$ 14,165,894	10.40*	9.75*
Montana	966	1,083	508	3,193,260	9.06	8.08
Nebraska	1,858	2,094	1,029	5,646,019	8.32	7.39
Nevada	--	--	--	--	--	--
New Hampshire	941	1,079	505	3,052,967	8.89	7.75
New Jersey	6,719	7,125	4,114	27,946,023	11.39	10.75
New Mexico	734	807	602	3,638,605	13.58	12.35
New York 12/.....	26,701	28,115	15,880	122,838,069	12.68	12.08
North Carolina	4,937	5,529	3,000	22,014,083	12.22	10.91
North Dakota	1,508	1,623	734	3,922,936	7.13	6.62
Ohio 13/.....	9,501	9,930	3,920	29,425,428	8.48	8.12
Oklahoma	2,046	2,243	1,555	9,353,793	12.52	11.42
Oregon 14/.....	2,964	3,038	1,439	12,785,013	11.82	11.53
Pennsylvania	11,169	11,425	6,963	64,123,370	15.73	15.38
Rhode Island	877	937	533	5,134,165	16.04	15.01
South Carolina	3,535	4,034	1,618	10,018,512	7.76	6.80
South Dakota	1,204	1,326	483	3,041,571	6.92	6.28
Tennessee	2,653	2,983	1,942	11,887,664	12.28	10.92
Texas 15/.....	10,821	11,685	5,844	36,967,666	9.36	8.67
Utah	910	934	562	3,572,383	10.75	10.48
Vermont	635	721	321	2,576,808	11.12	9.79
Virginia	3,702	3,938	1,425	10,353,837	7.66	7.20
Washington	3,996	4,141	2,479	22,502,076	15.43	14.89
West Virginia	488	491	475	2,058,864	11.56	11.49
Wisconsin	3,872	4,176	2,015	21,500,390*	15.21	14.11
Wyoming	609	721	373	2,104,704	9.47	8.00

TABLE 2 (CONTD.)

Provisional Patient Movement and Administrative Data: United States, FY 1970
Public Institutions for the Mentally Retarded
PATIENT MOVEMENT DATA

State	Number of Institutions	Resident Patients Beginning of Year	Admissions (excluding transfers)			Net Releases Alive From Institutions	Deaths in Institutions	Resident Patients End of Year
			Total	First Admissions	Readmissions			
United States 1/ ...	190	189,956	14,985	12,075	2,910	14,702	3,496	186,743
Alabama 2/.....	1	2,332	61	58	3	58	35	2,300
Alaska	1	101	17	16	1	9	0	109
Arizona	1	988	32	29	3	44	5	971
Arkansas 3/.....	1	1,130	337	324	13	162	11	1,294
California	9	12,545	628	566	62	1,380	310	11,483
Colorado	3	2,276	134	83	51	246	51	2,113
Connecticut 6/.....	8	4,102	662	282	380	588	102	4,074
Delaware	1	567	36	32	4	34	1	568
District of Columbia ...	1	1,285	106	45	61	127	22	1,242
Florida	6	6,018	528	453	75	258	160	6,128
Georgia	3	1,699	357	297	60	167	25	1,864
Hawaii	1	735	82	81	1	55	15	747
Idaho	1	720	108	59	49	155	19	654
Illinois 8/.....	6	8,533	424	250	174	916	164	7,877
Indiana	3	3,771	158	116*	42*	254	71	3,604
Iowa	2	1,711	116	85	31	170	34	1,623
Kansas	3	2,003	314	217	97	274	27	2,016
Kentucky	2	1,046	167	124	43	207	17	989
Louisiana	5	2,789	417	347	70	192	55	2,959
Maine 9/.....	1	839	101	85	16	130	11	799
Maryland	2	3,222	263	188	75	197	73	3,215
Massachusetts	8	7,767	369	277	92	433	149	7,554
Michigan	10	12,284	352	341*	11*	610	192	11,834
Minnesota	5	4,858	215	169	46	689	63	4,321
Mississippi	1	1,330	90	82	8	62	18	1,340

TABLE 2 (CONTD.)

PATIENT MOVEMENT DATA

State	Number of Institutions	Resident Patients Beginning of Year	Admissions (excluding transfers)			Net Releases Alive from Institutions	Deaths in Institutions	Resident Patients End of Year
			Total	First Admissions	Readmissions			
Missouri 11/	12	2,648	1,390	1,037	353	1,443	60	2,535
Montana	2	931	152	141	11	117	22	944
Nebraska	1	2,022	72	71	1	299	36	1,759
Nevada	--	--	--	--	--	--	--	--
New Hampshire	1	1,004	75	75	0	97	12	970
New Jersey	7	6,663	462	441	21	197	82	6,846
New Mexico	3	764	43	40	3	84	15	708
New York 12/	17	26,899	1,216	1,010	206	1,036	528	26,551
North Carolina	4	4,987	542	472	70	396	65	5,068
North Dakota	2	1,507	116	49	67	94	32	1,497
Ohio 13/	6	9,405	525	464	61	306	162	9,462
Oklahoma	3	1,980	263	248	15	289	20	1,934
Oregon 14/	3	2,943	95	85	10	169	33	2,836
Pennsylvania	9	10,837	588	435	153	580	224	10,621
Rhode Island	1	872	65	31	34	77	9	851
South Carolina	3	3,495	539	539	0	337	64	3,633
South Dakota	2	1,212	114	59	55	108	21	1,197
Tennessee	3	2,488	495	438	57	147	51	2,785
Texas 15/	10	10,566	1,119	937	182	459	189	11,037
Utah	1	849	85	83	2	48	23	863
Vermont	1	660	61	55	6	82	11	628
Virginia	2	3,616	322	300	22	203	74	3,661
Washington	5	4,005	136	132	4	349	54	3,738
West Virginia	1	471	20	19	1	24	6	461
Wisconsin	3	3,784	392	286	106	329	66	3,781
Wyoming	1	697	24	22	2	15	7	699

TABLE 2 (CONTD.)
Provisional Patient Movement and Administrative Data: United States, FY 1970
Public Institutions for the Mentally Retarded
PATIENT MOVEMENT RATIOS

State	Rate Per 100,000 Civilian Population 18/		Rate Per 1,000 Average Resident Patients 19/			Net Releases Per 1,000 Total Admissions
	Total Admissions	Resident Patients End of Year	Total Admissions	Net Releases Alive from Institutions	Deaths in Institutions	
United States 1/....	7.5	94.2	78.4	76.9	18.3	1217.5
Alabama 2/.....	1.8	67.5	26.3	25.0	15.1	950.8
Alaska	6.3	40.5	161.9	85.7	--	529.4
Arizona	1.8	55.7	32.7	44.9	5.1	1375.0
Arkansas 3/.....	17.6	67.6	278.1	133.7	9.1	480.7
California	3.2	58.7	52.3	114.9	25.8	2197.4
Colorado	6.2	98.2	61.1	112.1	23.2	1835.8
Connecticut	21.9	134.9	161.9	143.8	25.0	888.2
Delaware	6.6	105.0	63.5	60.0	1.8	944.4
District of Columbia ...	14.3	167.2	83.9	100.6	17.4	1198.1
Florida	7.9	91.6	86.9	42.5	26.3	488.6
Georgia	8.0	41.6	200.4	93.8	14.0	467.8
Hawaii	11.5	104.8	110.7	74.2	20.2	670.7
Idaho	15.2	92.4	157.2	225.6	27.7	1435.2
Illinois	3.8	71.3	51.7	111.6	20.0	2160.4
Indiana	3.0	69.5	42.9	68.9	19.3	1607.6
Iowa	4.1	57.5	69.6	102.0	20.4	1465.5
Kansas	14.2	91.4	156.3	136.4	13.4	872.6
Kentucky	5.3	31.2	164.2	203.6	16.7	1239.5
Louisiana	11.6	82.1	145.1	66.8	19.1	460.4
Maine 9/	10.3	81.4	123.3	158.7	13.4	1287.1
Maryland	6.8	83.3	81.7	61.2	22.7	749.0
Massachusetts	6.5	133.6	48.2	56.5	19.5	1173.4
Michigan	4.0	133.6	29.2	50.6	15.9	1732.9
Minnesota	5.7	113.7	46.9	150.1	13.7	3204.7
Mississippi	4.1	61.3	67.4	46.4	13.5	688.9

TABLE 2 (CONTD.)

PATIENT MOVEMENT RATIOS

State	Rate Per 100,000 Civilian Population 18/		Rate Per 1,000 Average Resident Patients 19/			Net Releases Per 1,000 Total Admissions
	Total Admissions	Resident Patients End of Year	Total Admissions	Net Releases Alive from Institutions	Deaths in Institutions	
Missouri	30.0	54.7	536.5	556.9	23.2	1038.1
Montana	22.1	137.2	162.2	124.9	23.5	769.7
Nebraska	4.9	119.4	38.1	158.2	19.0	4152.8
Nevada	--	--	--	--	--	--
New Hampshire	10.2	132.2	76.0	98.3	12.2	1293.3
New Jersey	6.5	96.4	68.4	29.2	12.1	426.4
New Mexico	4.3	70.9	58.4	114.4	20.4	1953.5
New York 21/	6.7	146.3	45.5	38.8	19.8	852.0
North Carolina	10.9	102.3	107.8	78.8	12.9	730.6
North Dakota	19.1	246.6	77.2	62.6	21.3	810.3
Ohio 13/	4.9	89.0	55.7	32.4	17.2	582.9
Oklahoma	10.4	76.7	134.4	147.7	10.2	1098.9
Oregon 14/	4.6	135.9	32.9	58.5	11.4	1778.9
Pennsylvania	5.0	90.2	54.8	54.0	20.9	986.4
Rhode Island	7.0	92.2	75.5	89.4	10.4	1184.6
South Carolina	21.4	144.4	151.2	94.6	18.0	625.2
South Dakota	17.2	181.1	94.7	89.7	17.4	947.4
Tennessee	12.7	71.6	187.8	55.8	19.3	297.0
Texas 15/	10.2	100.3	103.6	42.5	17.5	410.2
Utah	8.1	81.8	99.3	56.1	26.9	564.7
Vermont	13.7	141.4	94.7	127.3	17.1	1344.3
Virginia	7.2	82.0	88.5	55.8	20.3	630.4
Washington	4.1	112.1	35.1	90.2	13.9	2566.2
West Virginia	1.1	26.4	42.9	51.5	12.9	1200.0
Wisconsin	8.9	85.6	103.6	87.0	17.5	839.3
Wyoming	7.3	212.5	34.4	21.5	10.0	625.0

FOOTNOTES

1/ The United States total does not include Nevada since Nevada has no public institutions for the mentally retarded.

2/ Alabama: Data reported was for the fiscal year ending September 30, 1970.

3/ Arkansas: The Arkansas Children's Colony consists of three residential units located in various geographical settings within the State which are centrally administered and funded. In addition there is a rehabilitation unit with residential capacity for 80 trainees. The expenditure figures do not include costs associated with the rehabilitation unit nor do they reflect any other monies than those from State appropriations.

4/ California: In some instances personnel data reflect hospital employees who treat both the mentally retarded and the mentally disordered.

5/ Colorado: Expenditure figures include some Federal funds.

6/ Connecticut: Of the eight facilities included in their report six are regional centers and two are considered training schools. The latter are large long-term-stay facilities which provide services to nearly 90% of residential patient population.

7/ Georgia: The data as presented are agregate figures for all State-run facilities with residential capacity. Thus the expenditures as reported includes services to day patients, night patients, and inpatients at two retardation centers opened during the year.

8/ Illinois: The readmissions figures include 57 transfers from State hospitals and the net release figures include 265 transfers to State Hospitals.

9/ Maine: Pineland Hospital and Training Center is a dual purpose facility. Only data pertaining to mentally retarded are reported here.

10/ Minnesota: One new center was opened at the end of the fiscal year and another facility was closed. In computing daily maintenance expenditures 465 average daily patients and 645 patients under treatment were excluded since expenditure figures were not available for the facilities providing residential services for these patients.

11/ Missouri: Two new facilities that provide inpatient services were opened this year. This increases the number of the 40-bed Regional Diagnostic Centers to nine within the State system in addition to the three State School-Hospital facilities. The daily maintenance expenditures computations are estimated figures for just the three long term stay residential institutions.

12/ New York: Data reported was for the fiscal year ending March 31, 1970. Data on personnel, maintenance expenditures excludes Albion State Training School and Beacon State Institution. Maintenance expenditures are also excluded for New York State Research Institute. Therefore, the maintenance expenditure computations and therefore these ratios reflect a slightly lower value than if the data had been excluded.

13/ Ohio: Includes data on the mentally retarded patients at the following dual purpose institutions: Cambridge State Hospital and Springview Hospital. Personnel and maintenance expenditures for these two facilities were not included. However, the ap-

proximately 300 mentally retarded patients at these dual purpose facilities were not excluded from the daily maintenance expenditure computations and therefore these ratios reflect a slightly lower value than if the data had been excluded.

14/ Oregon: Resident patients were defined as those who were physically present or on pass three days or less.

15/ Texas: Data reported was for fiscal year ending August 31, 1970. Includes data from San Angelo State School and Corpus Christi State School which opened October 7, 1969 and June 1, 1970 respectively. In computing daily maintenance expenditures for Texas 46 average daily patients and 66 patients under treatment and $573,767 in expenditures were excluded for Corpus Christi State School.

16/ Per resident patient maintenance expenditures are based on the average daily resident patient population of institutions reporting expenditures.

17/ Per patient under treatment maintenance expenditures are based on the patients under treatment (resident patients beginning of year plus total admissions) for institutions reporting expenditures.

18/ Admission and resident patient end of year rates are per 100,000 estimated civilian population. Sources: U.S. Bureau of Census, Current Population Reports, Series P-25, provisional estimate for April 1970. (Civilian population for State of Nevada has been subtracted from the U.S. civilian population since Nevada has no public institutions for the mentally retarded).

19/ These rates are based on the average of the beginning and end of year resident patient populations.

Symbols used: *Indicates data which are estimated or include estimates.

--Data not available.

Programs for the Deaf-Blind-Retarded

The Hospital Improvement Project, administered by the Division of Developmental Disabilities, has supported a number of programs for the multi-handicapped in state mental retardation institutions. One such program is in operation at the Mansfield Training School in Connecticut; a brief summary of this activity follows:

MANUAL LANGUAGE PROGRAM AT MANSFIELD TRAINING SCHOOL

The primary objective of the Manual Language program at Mansfield Training School is to provide residents who are deaf, hard of hearing, or who can hear but not speak with a means of communication. The method used to teach these residents is combined manual language (signs) and oral language (speech), with the instructors in the classrooms signing and speaking at the same time.

Three instructors have classes for residents on a 1/2 day basis, one for school-aged children and two for adults. Classes for the school aged are held in a school classroom which is equipped with an EFI loop system to provide amplification for residents and is also specially sound treated with rugs, draperies and acoustical tiles.

The two instructors teaching 28 adults in classrooms in the Speech and Hearing Department use the combination of manual and oral language. The curriculum is composed of a core vocabulary of signs needed for daily living skills plus progressively advanced signs for learning pre-vocational and vocational skills. This vocabulary is developed into meaningful phrases and sentences depending upon the resident's abilities. In addition to eaching the development of communication skills, emphasis is placed also on teaching social and job-oriented skills.

Instruction in manual language has been given to staff in the Residential Care Department and the Workshop at Mansfield, as well as to personnel at Goodwill Industries in Springfield, Massachusetts. Three of the residents who started in the program are employed full-time at Goodwill and three work in Mansfield's Candle Shop.

The genesis of the Manual Language Program was a tutorial program with the University of Connecticut and the Speech and Hearing Department in 1969-70. Thirteen volunteers, who were taught signs by the student director who was proficient in signing, taught these signs to 13 adult residents once weekly for 13 weeks. The encouraging results of this pilot program were transmitted to personnel in the Hospital Improvement Program who are concerned with identifying the needs of severely and profoundly retarded and multiply-handicapped adults, and had recognized the needs of these residents for methods of communication. The specially equipped classroom evolved to meet the needs of school children for communication.

Neither mental level nor age of residents are important factors in the selection of adult candidates for the program, although some consideration is given to the possibility of eventual employment. Residents who have been evaluated

and considered potential signers are given instruction in the classroom or individually on a trial basis. The program is adapted for utilizing behavior modification principles.

Limited efforts have been made to continue the use of total communication in the dormitories in which the residents live. To completely round out the training of these residents in this primary setting, plans are being discussed for a Communication Training Center which will not only be the living area for the residents but will also be an area of communication consciousness between resident and resident, resident and staff, and staff and staff.

The Headmaster-Director of the American School for the Deaf in Hartford and his staff have shown a great deal of cooperative interest in the program. Continued development of the program, particularly with the resources and understanding of the American School and other facilities, may provide us with another avenue for the development of our resident's latent potential.

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Lead Poisoning

On February 8, 1972, the President sent to Congress a message outlining his environmental program. Included in that message is the following reference to lead poisoning:

PROTECTING CHILDREN FROM LEAD-BASED PAINT

To many Americans, "environment" means the city streets where they live and work. It is here that a localized but acutely dangerous type of "pollution" has appeared and stirred mounting public concern.

The victims are children: the hazard is lead-based paint. Such paint was applied to the walls of most dwellings prior to the 1950's. When the paint chips and peels from the walls in dilapidated housing, it is frequently eaten by small children. This sometimes results in lead poisoning which can cause permanent mental retardation and occasionally death. We can and must prevent unnecessary loss of life and health from this hazard, which particularly afflicts the poorest segments of our population.

To help meet the lead-paint threat, the Department of Health, Education, and Welfare will administer grants and technical assistance to initiate programs in over 50 communities to test children in high-risk areas for lead concentrations. In addition, these programs will support the development of community organization and public education to increase public awareness of this hazard. Other Federal agencies are also active in the effort to combat lead-based paint poisoning. ACTION and other volunteers will assist city governments to help alleviate lead paint hazards. The Department of Housing and Urban Development is engaged in research and other actions to detect and eliminate this hazard.

The resources of the private sector should also be utilized through local laws requiring owners of housing wherever possible to control lead paint hazards.

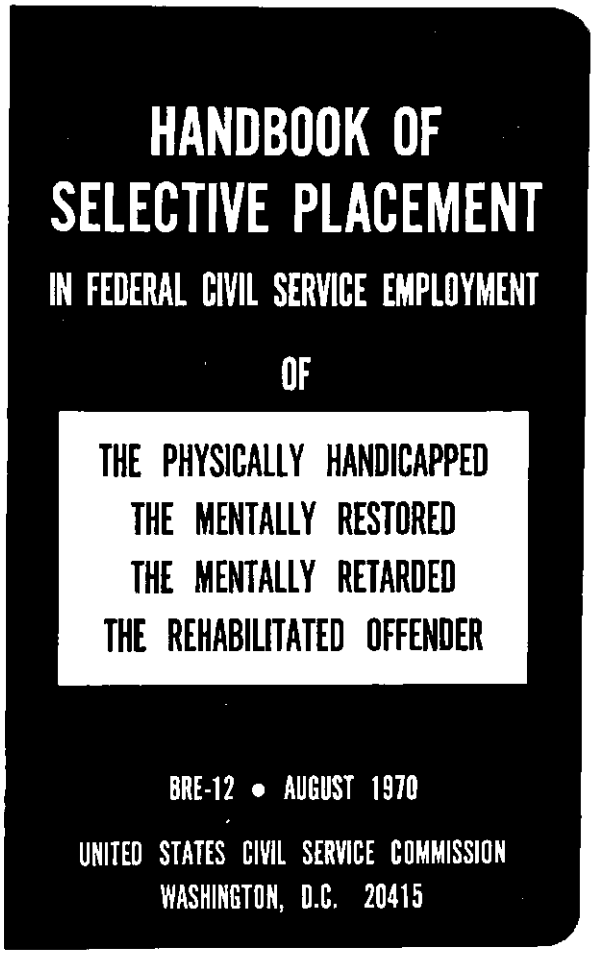
(Presidential Documents, February 14, 1972, Vol. 8, No. 7, page 226).

The National Bureau of Standards projections for national annual statistics on childhood lead-based paint poisoning are as follows:

Children at risk	2,500,000
Children with elevated blood-lead levels (over 40 ug/100 ml)	600,000
Cases of symptomatic lead poisoning	30,000
Children with neurological handicaps, including mental retardation	6,000
Children requiring life time institutional care	150
Deaths	200

For other information on lead poisoning, see "Programs for the Handicapped" No. 71-8.

The Department of Health, Education, and Welfare has employed over 600 mentally retarded persons in a variety of jobs since this special employment program began in 1964; this program is directed by the U.S. Civil Service Commission. Two publications of the Commission are of particular interest to persons in the mental retardation field.



HANDBOOK OF SELECTIVE PLACEMENT
in Federal Civil Service Employment
of
The Physically Handicapped
The Mentally Restored
The Mentally Retarded
The Rehabilitated Offender

"The Federal Government, as the nation's largest single employer, can do no less than other employment sectors in furthering those public policy, socially oriented programs which the Administration recommends to everyone. In fact, as President Nixon said, the Federal Government must 'lead the way as an equal opportunity employer'."

Robert E. Hampton, Chairman
U.S. Civil Service Commission

This Handbook is in looseleaf form and contains: information about the Federal employment program, discussions of various handicapping conditions, and a presentation of the roles of agency coordinators and rehabilitation counselors.

The Handbook is available from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402 - Price 60 cents. (Give title and BRE-12, August 1970). This publication is not available from any other source.

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EMPLOYMENT OF THE MENTALLY RETARDED IN FEDERAL SERVICE

This is a brochure outlining the basic features of the Federal Civil Service employment program for the mentally retarded.

Copies are available without charge from the Office of Public Policy Employment Programs, Manpower Sources Division, BRE, U.S. Civil Service Commission, Washington, D.C. 20415 (Give No. BRE-7).

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INTERNATIONAL DIRECTORY OF MENTAL RETARDATION RESOURCES

Information about mental retardation programs in foreign countries has long been needed by persons working in the international field. A Directory of these programs for 58 countries has been produced through the cooperation of the National Institute of Child Health and Human Development and the President's Committee on Mental Retardation.

Information provided for each country includes a short history of the country, a list of governmental agencies with primary responsibility for mental retardation, voluntary and other organizations concerned with mental retardation, publications which include articles of interest, brief descriptive notes on program areas in the field, and a section with helpful information for visitors.

Single copies of the Directory are available without charge from the Office of Mental Retardation Coordination, U.S. Department of Health, Education, and Welfare, Washington, D.C. 20201.