Office of
Mental Retardation Coordination

programs for the handicapped

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Focus On Day Care

by
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Department of Health, Education, and Welfare

"What is good day care? Where can I find it? How much will it cost me? How do I know that the program will be good for my child?"

Questions like these are now being asked by thousands of working mothers throughout the country, and will be asked by thousands more after the passage of proposed welfare reform legislation by Congress.

At the Office of Child Development, it is our job to answer these questions, to provide information about day care to parents and groups, and--perhaps most important of all--to act as advocates for the good quality day care that the children of this Nation need and must have.

OTHER ITEMS

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

That is the kind of day care President Nixon asked for when he first presented his welfare reform program to Congress in 1969. The President emphasized that the care he planned for the children of mothers in job training or employed through the program would be the type that contributes to a child's growth and development.

What the President proposed was developmental day care--and a lot of people are just a little hazy about what developmental day care is. Let me try to define it by first telling what it is not, and then describing what I believe it is.

Developmental day care should be distinguished from two other types of child care--comprehensive and custodial. Comprehensive day care offers the widest possible range of educational, health and counseling services to children and their parents. Such programs are very expensive, and most American families can provide for the growth and development of their children without requiring such broad services from the Government.

At the other extreme, custodial day care does little more than insure the supervision and physical safety of children whose mothers are at work. Because there are no planned activities in this kind of day care and no opportunities for children to build a sense of self-worth, the Administration does not propose to support custodial care.

Developmental day care, which the Administration would like to see for children of working mothers, provides a child with many opportunities for physical, social and intellectual development. Under the supervision of trained workers, each child takes part in planned educational and recreational activities. He receives nutritious meals and medical and dental examinations and followup. And his parents are encouraged to participate actively in the program.

Developmental day care can be made available to preschoolers or to school-age children after school hours. It can be offered at day care centers, in family day care homes, or in the child's own home through home-based programs.

The Office of Child Development has always sought developmental day care for children. We have said that a child needs more than just a safe sandbox to play in or a TV set to look at. In the issue of Children Today for January/February 1972, you will find a number of articles describing different aspects of the kind of developmental care we seek.

One thing is clear, however. We cannot have quality developmental day care for the children of this Nation without educators who have the knowledge and ability to care for and teach young children.

There is a pressing need for trained personnel for programs for children. Since 1960, the number of licensed day care facilities in this country has tripled. At the present rate of growth, kindergarten and preschool enrollment, which was 3.9 million in 1968, will climb to 6.3 million by 1980.

But this rate of growth does not allow for the day care programs now under consideration by Congress. Proposed legislation anticipates that 800,000 children will be served in the first full year of welfare reform. Teachers in early childhood education are in very short supply now; as child care services expand,

thousands of new educators will be needed.

Where will we find them? To meet this urgent need, the Office of Child Development will begin a program in 1972 to develop a new profession for child care workers. Called child development associates, they will be men and women who are qualified through training and experience to care for and teach a group of children independently.

Child development associates will not replace teachers with college degrees, nor will they simply serve as aides. They will be capable staff members who have been recognized for their ability to work with young children.

OCD will develop training programs for this new cadre of child care workers and will establish a national system of accreditation and certification, based on demonstrated competency in the field rather than on the completion of formal courses.

With the valuable help of professional organizations, this new OCD program is now being developed and will be introduced this year. It will be a large-scale effort, and we regard it as an important one. You will be hearing much more about child development associates, just as you will be hearing much more about day care during the years ahead.

Millions of children will need day care during the 1970's. Let's see that these children get good, developmental day care, and let's not settle for less.

Edward Zigler

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Standards For Residential Facilities For Mentally Retarded Now Ready

by
Allen R. Menefee[1/]

Quality of residential care of the mentally retarded has long been the concern of professionals, consumers and citizens. This quality is about to be realized through the application of high standards through an accreditation process administered by a body long recognized for its achievements and leadership in accreditation of facilities for human services. A categorical council of the Joint Commission on Hospital Accreditation known as the Accreditation Council for Facilities for the Mentally Retarded has accomplished the first of two major steps in improving rhe quality of residential services provided mentally retarded persons by establishing standards for residential facilities for the mentally retarded.[2/] The second step is the field testing of survey procedures to determine the degree to which a given facility meets these standards.

The Council is made up of two representatives from each of the following organizations: American Association on Mental Deficiency, American Psychiatric Association, Council for Exceptional Children, National Association for Retarded Children, and United Cerebral Palsy Association, Inc.[3/] Its work has been chiefly supported by the Division of Developmental Disabilities of the Social and Rehabilitation Service. A planning committee included the American Medical Association.

Recognizing that chronic nature of mental retardation which cuts across every aspect of life, the Council sought assistance from every organization interested in mental retardation. This was accomplished through 23 advisory committees made up of more than 200 representatives of the many interested organizations. All possible disciplines, technical and consumer interests were included. The standards were then edited, approved and ranked by the Council and are now the official standards of the Joint Commission for accrediting purposes.

The standards are divided into seven sections: Administrative Policies and Practices, Resident Living, Professional and Special Programs and Services, Records, Research, Safety and Sanitation, and Administrative Support Services.

The following material will discuss and illustrate highlights of each of the sections.

1/ Mr. Menefee is Assistant Professor of the School of Social Welfare, Florida State University, Tallahassee, Florida, and also serves as a consultant to the Office of Mental Retardation Coordination.

2/ Copies of the publication, Standards for Residential Facilities for the Mentally Retarded are available from the Accreditation Council for Facilities for the Mentally Retarded, 645 N. Michigan Avenue, Chicago, Illinois 60611. Loose leaf issues are $6.00, soft bound editions are $3.50.

3/ See page 9 for names of Councillors.

ADMINISTRATIVE POLICIES AND PROCEDURES

The Standards require that the facility's goal be consistent with the principle of normalization, defined as "the use of means that are as culturally normative as possible to elicit and maintain behavior that is as culturally normative as possible, taking into account local and subcultural differences."

This means that descriptive words for residents and names of facilities stress appropriate function as opposed to deviancy, such as "residents," "clients," "trainees," instead of "inmates," "kids," and "patients" except when the latter are in hospital treatment. Facilities should be located in and be community oriented rather than geographically, psychologically, or administratively isolated. Integration of residents in generic or specialized community services for health, education, leisure, work, shopping and religious expression should be provided along with public and professional education to accomplish this integration.

This philosophy is expressed in the standard 1.1.6, "The facility shall make every attempt to move residents from more to less structured living; larger to smaller facilities; larger living units to smaller living units; group to individual residence; dependent to independent living; and segregated to integrated living."

Standards require the faculty to clearly state in writing its philosophy, goals, and objectives, its policies and procedures, its legal authorization and framework, and its plan for evaluation. These are to be promulgated to its staff, consumer representatives and the public. The policies and procedures shall assure civil rights of its residents in "accordance with its Declaration of General and Special Rights of the Mentally Retarded of the International League of Societies for the Mentally Handicapped" and "define the means of making legal counsel available to residents for protection of their rights."

Standards further call for a governing body with an executive officer who has authority and responsibility, sound management practices; a program for staff improvement and staff participation; a continuing data collection and analysis system and a public information statement on clientele and services. Standards further call for consumer and public participation.

Standards for admission and release are centered on the philosophy that it should serve only those who truly need its services, and only for so long as those services are needed. Provisions are made for both preadmission and annual interdisciplinary review.

Personnel policies standards provide optimum employment conditions and staff development with the welfare of the resident as the ultimate goal.

RESIDENT LIVING

The primary function of the resident-living personnel is to provide a warm, family homelike atmosphere conducive to achievement of optimal development of the resident. This includes attention and training in a consistent interpersonal relationship with diversity with excessive housekeeping and clerical

tasks.

The Standards are most important in this section because they cover the bulk of the resident's life while living in the facility. They guarantee an individual plan for each resident and include the normal "rhythm of life" in day to day activities, normal heterosexual interaction, democratic participation and free and unsupervised use of communication and personal belongings. These standards outlaw censorship of mail and denial of use of telephone.

Management of behavior problems must be based on a written statement of policies and procedures, the formulation of which the resident has had an opportunity to participate. Not permitted are corporal punishment, seclusion in a locked room, or discipline by other residents. Restraints shall not be employed as punishment, for the convenience of staff, or as a substitute for program. This section of the Standards also makes clear statements on mechanical supports, chemical restraints, the use of "time out" and noxious or adversive stimuli in behavior modification.

Standards for food services are best expressed in the statement, "Food services shall recognize and provide for the physiological, emotional, and cultural needs of each resident, through provision of a planned nutritionally adequate diet." Such services are sound examples of the application of the normalization principle to daily functions of eating.

Clothing standards providing for neat, clean, fashionable and reasonable clothing through its residents' own choice and training again express the normalization principle in residential life.

The Standards in meeting needs for health, hygiene and grooming require daily tooth brushing, bathing, care of nails, individual hair styling, toilet training as indicated, attention to growth indicators such as weight and height and access to sanitary drinking water.

With the goal of the "development of meaningful interpersonal relationships among residents and between residents and staff," the standards for grouping and organization of living units call for program units of not more than eight and living units of not more than sixteen. The standards require integration of persons with additional handicaps (deaf, blind, epileptic, etc.) with their peers of comparable social and intellectual development, and prohibits grouping together those "grossly different ages, developmental levels and social needs--unless such housing is planned to promote the growth and development of all those housed together." Standards further require free access to all areas of the living unit as well as the out-of-doors.

Standards call for sufficient resident living staff who are qualified and trained to conduct the daily living program. The Standards set overall staff-resident ratios for 24-hour seven day a week coverage. The overall staff-resident ratio should be one to one for medical and surgical units, and for units including infants, children, adolescents requiring considerable adult guidance and supervision, severely physically handicapped, and residents who are aggressive, assaultive, or security risks, or who manifest severely hyperactive or psychotic-like behavior. Applied to a five-day work week with

allowance for holiday, vacation, and sick time, this would break down by shift to: first shift 1:4, second shift 1:4, and third shift 1:8.

For units serving moderately retarded adolescents and adults requiring habit training, the overall ratio is 1:1.25. For units serving residents in vocational training programs and adults who work in sheltered employment situations, the overall staff-resident ratio should be 1:2.5.

Standards for design and equipage of living units contain certain essential elements aimed at the enhancement of personal and social development including simulation of home and personalized atmosphere. Provisions are made for adequate space and design for safety, personal belongings, training and a variety of opportunities. Minumum space requirements for living, dining or activity space is 80 square feet per resident and 60 square feet of bedroom space in multiple sleeping units or 80 square feet in single bedrooms. Individual furniture and beds are also prescribed.

PROFESSIONAL AND SPECIAL PROGRAMS AND SERVICES

This section of the standards is predicated on an individualized specific program which allows for optimum growth of each resident. It covers the following professions, disciplines or areas of service: Audiology, Dentistry, Education, Food and Nutrition, Library Services, Medicine, Music, Art and Dance and other activity therapies, Nursing, Occupational Therapy, Pharmacy, Physical Therapy, Psychology, Recreation, Religion, Social Work, Speech Pathology, Vocational Rehabilitation and Volunteer Services.

The Accreditation Council believes that every retarded individual in a residential facility is entitled to the same degree of professional service as afforded the non-retarded in the general community. Each professional section therefore requires that that program be administered or supervised by an individual who meets the highest level of education and achievement within his profession as expressed by that professional organization's own standards, and further that he or she be fully conversant with the application of his professional knowledge and skills to the needs of the mentally retarded. Professional and associated personnel must meet licensing, certification or accrediting standards for the state in which they are employed. Subscription to the disciplines code of ethics is required. Each professional section calls for staff development through in-service training, university affiliation, consultation and conference and workshop participation.

While the unique contributions of each profession are indicated in the Standards, emphasis is placed on the interdisciplinary team approach.

RECORDS

The Standards require permanent individual record for each resident which shall serve as a tool for planning and implementing and evaluating his developmental program. In addition to spelling out the detailed information necessary to the record, the Standards mandate confidentiality, provide for access by authorized personnel in both unit and central records systems, and recommend certain statistical records be kept. Mandated too is sufficient, appropriately

qualified staff who are supervised by a Registered Record Librarian, an accredited record technician, or an individual who "has demonstrated competence and experience in administering and supervising the maintenance and use of records and reports."

RESEARCH

Facility administration and staff "shall encourage research activity" with written policy and provision of opportunities and resources to investigators recommended by the Accreditation Council.

An interdisciplinary research committee is required to review all proposed studies. Residents are protected in the Standards by the American Association on Mental Deficiency Statement on the Use of Human Subjects for Research.

SAFETY AND SANITATION

This section of the Standards protects and enhances the life of the residents through state and local and national fire safety codes, requirements relative to prevention of architectural barriers, a disaster plan, safety devices and other environmental protection factors such as prohibition of lead paint, requirements for garbage disposal, and other sanitary measures.

ADMINISTRATIVE SUPPORT SERVICES

Recognizing that program services for residents are delivered efficiently through effective administrative support services, the Accreditation Council requires their provision through a variety of resources including budgetary and fiscal affairs, clerical, communications, dietary, housekeeping, laundry, personnel, physical plant records, safety, security, supply, and purchasing. Personnel in these various functions must have "sufficient understanding and appreciation of the nature and behavior of the mentally retarded residents to assure that each employee's work and his relations to the residents contribute positively to their welfare."

CONCLUSION

The Standards for Residential Facilities for the Mentally Retarded have many useful applications. They may be used as a tool for self-study and examination by an individual facility and its staff or by a state or private organization in reviewing the quality of its residential services. It may be utilized as a study document for in-service training or a voluntary consumers group as an instrument of understanding of the philosophy and nature of a commendable residential facility.

Facilities desiring further information on accreditation should contact Kenneth G. Crosby, Ed.D., Program Director, Accreditation Council for Facilities for the Mentally Retarded, Joint Commission on Accreditation of Hospitals, 645 North Michigan Avenue, Chicago, Illinois 60611.

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Mental Retardation And Maternity And Infant Care Program

The Maternity and Infant Care Projects, which were initiated in 1964 with the funding of the first project in Baltimore, Maryland, have produced concrete evidence that they can be a factor in the reduction of infant mortality among project populations.

A perspective of this progress can be seen through reductions reported by some of the 56 Special MIC Projects which are now operating. For example, in Houston, Texas, the infant mortality rate was 28.0 for 1965, and in 1970, had dropped to 20.0. In St. Louis, Missouri, it went down from 44.4 per 1,000 live births in 1965 to 31.1 in 1970. In Chicago, the reduction was from 33.6 in 1965 to 27.7 in 1970.

The projects have also made progress in the prevention of mental retardation, although it cannot be measured by a single index. Analysis of a number of factors which are known to have a causal relationship to mental retardation does show the activities of the Maternity and Infant Care program in this area:

For example, between 1964, when the M&I Project was instituted at Atlanta, Georgia's Grady Hospital and 1970, here is what happened to the black premature birth rate: It dropped from 19 to 16 percent; the number of premature newborns weighing 1,501 to 2,000 grams decreased from 253 in 1964 to 192 in 1970; and the number of premature newborns weighing 2,001-2,500 grams decreased from 738 in 1964 to 519 in 1970.

In other projects, similar reductions have been registered which show progress against the hazards of premature birth: At the Omaha, Nebraska M&I Project, the rate of premature births went down from 15.7 for 1965 to 10.9 for 1969. In Dade County, Florida, the percentage of prematures went down from 13 percent in 1967 to 11.3 percent in 1970. In the New York City MIC-FP Project, the premature birth rate dropped from 12.1 in 1969 to 11.6 in 1970.

Data gathered from the Maternity and Infant Care Projects seems to indicate that there has been some decrease in the percentage of older MIC patients--those 35 years or older. During the first half of 1969, for example, 5.2 percent of the white patients and 4.9 percent of the black patients were 35 years and over. During the last half of 1970, 315 percent of the white and 3.9 percent of the black patients were 35 years of age or older.

Projects are making substantial reductions in the number of mothers being delivered without any prenatal care. In St. Louis, Missouri, over the past 5 years, the number of project mothers delivering without prenatal care was reduced from 20 percent to 10 percent. In Albuquerque, New Mexico, the proportion of women in the project area delivering without prenatal care dropped from 45 percent in 1967 to 10 percent in 1970. In Greenville, South Carolina, the proportion dropped from 25 percent in 1967 to 5.9 percent in 1970. In Minneapolis, at the County Hospital, the proportion declined from 43 percent in 1966 to 13 percent in 1970.

The number of women who request help early in pregnancy, so that they get the

most benefit from prenatal care also is on the increase. Here are rates reported in five M&I Projects in the percent of patients registering in the first trimester of pregnancy: Tri-County, Colorado, from 31.1 in 1969 to 37.2 in 1970; Minneapolis, Minnesota, from 15.3 in 1965 to 25.2 in 1970; St. Paul, Minnesota, from 10.3 in 1967 to 18.2 in 1970; Greenville, South Carolina, from 11.8 in 1967 to 24.6 in 1970; and Baltimore, Maryland, from 9 in the first three months of 1964 to 50 in the first three months of 1971.

These figures give an indication that the M&I Projects are responding to the needs of thousands of women of low income, especially those in large cities, who have been giving birth prematurely from two to two and one-half times the expected rate. Low birth weight babies are at risk from brain damage, and recent statistics show that the rate of low birth weight is higher among non-white births (13.9) than for white infants (7.2).

In the Maternity and Infant Care Projects the proportions of low birth weight infants is highest among women less than 18 and more than 35 years of age. Childbearing characteristically starts earlier in low income groups and continues longer than in the middle class and pregnancy occurs at closer intervals.

The characteristics of the women admitted to the projects include a much higher proportion of high risk factors than is generally true of women giving birth in this country. A history of previous pregnancies terminating in fetal loss and premature delivery, as well as obesity and underweight, anemias and cardiovascular disease are the common medical complications of pregnancy.

One of the objectives of the Maternity and Infant Care Program is to take steps which will assist communities in organizing their maternity and infant care services so as to increase the accessibility of care, to improve the quality of care and to make use of the best available resources in providing comprehensive maternity and infant care for low-income high-risk patients.

In many respects, the Maternity and Infant Care Special Projects have served as a prototype of several subsequent programs with similar objectives of altering the prevailing patterns of providing medical care for the poor.

Additional information about Maternity and Infant Care Projects may be secured from Maternal and Child Health Service, Health Services and Mental Health Administration, Department of Health, Education, and Welfare, Parklawn Building, 5600 Fishers Lane, Rockville, Maryland 20852.

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Mental Retardation Funds
Department of Health, Education, and Welfare
Fiscal Years 1971-1973

The material on the following pages presents the amount of funds available from the Department of Health, Education, and Welfare for mental retardation programs. Six agencies and offices within the Department administer mental retardation funds that support programs covering a wide spectrum: services, training, construction, research and income maintenance. The first four of these activities represent an estimated obligation of about $538 million in FY 1973. The income maintenance program will obligate $341 million during this same year.

The programs operated with these funds are described in the report of the Office of Mental Retardation Coordination entitled "Mental Retardation Activities, 1972" which will be available from the Superintendent of Documents, Washington, D.C. 20402 about July 1 (price undetermined). Additional information concerning these tables may be secured from the Office of Mental Retardation Coordination, or from the agency administering the program.

GLOSSARY OF TERMS*

FISCAL YEAR -- Year running from July 1 to June 30 and designated by the calendar year in which it ends.

AUTHORIZATION -- Basic substantive legislation which sets up a Federal program or agency either indefinitely or for a given period of time. Such legislation sometimes sets limits on the amount that can subsequently be appropriated, but does not usually provide budget authority.

BUDGET AUTHORITY -- Authority provided by the Congress--mainly in the form of appropriations--which allows Federal agencies to incur obligations to spend or lend money. While most authority is voted each year, some becomes available automatically under permanent laws--for example, interest on the public debt.

OBLIGATIONS -- Commitments made by Federal agencies to pay out money for products, services, loans, or other purposes--as distinct from the actual payments. Obligations incurred may not be larger than the budget authority.

FEDERAL FUNDS -- Funds collected and used by the Federal Government, as owner. The major federally owned fund is the general fund, which is derived from general taxes and borrowing and is used for the general purposes of the Government. Federal funds also include certain earmarked receipts, such as those generated by and used for the operations of Government-owned enterprises.

TRUST FUNDS -- Funds collected and used by the Federal Government, as trustee, for specified purposes, such as social security and highway construction. Receipts held in trust are not available for the general purposes of the Government. Trust fund receipts which are not anticipated to be used in the immediate future are generally invested in Government securities and earn interest.

*"The U.S. Budget in Brief, FY 1973," Executive Office of the President, Office of Management and Budget, January 1972.

EXPLANATORY NOTES ON MENTAL RETARDATION OBLIGATION TABLES

Definitions:

Services: Includes services rendered in behalf of the mentally retarded as well as direct services offered to the mentally retarded. For example, case finding, information and referral programs are included, along with direct medical care and special education programs.

Training: Includes training of professional as well as supportive personnel. For example, university graduate level training and in-service training in mental retardation institutions are both included. Also, no distinction is made between training for service and training for research.

Estimates: Inadequate reporting data on some programs necessitate the use of very rough estimates on amount of funds. This is especially true of Medicaid (Title XIX, SSA); the amount shown is based on data from only a limited number of states.

Omission: No data suitable for determining obligations is available in the public assistance social service program. Even though many States are known to use these funds to support services for the mentally retarded, no reporting procedure exists to determine extent and cost of such activities.

Developmental Disabilities: Funds authorized under P.L. 91-517 became available for the first time in FY 1971; this statute authorizes funds for mental retardation as well as other types of disabilities, e.g., cerebral palsy and epilepsy. However, for fiscal accounting purposes, all funds obligated under P.L. 91-517 are considered in the area of mental retardation.

Income Maintenance: Obligations for income maintenance support under social security and public assistance are separately identified in the tables. These amounts are based on estimated numbers of mentally retarded persons receiving benefits. Such obligations should be considered in a separate category from those funds appropriated for the support of programs designed specifically for mental retardation programs or known to be related to mental retardation to a significant degree.

Table 1

Summary Tables

DHEW Mental Retardation Obligations
FY 1971-1973
(Thousands of Dollars)

1. Agency-Activity Summary	1971	1972	1973
Office of Education			
Services	$67,820	$74,610	$77,354
Training	11,900	11,900	12,320
Research	1,420	1,600	1,664
Other	69	69	69
Total	$81,209	$88,179	$91,407
Health Services and Mental Health Administration			
Services	$13,148	$19,739	$21,479
Training	17,312	19,683	19,923
Research	2,299	2,299	2,299
Other	2,395	1,300	1,300
Total	$35,154	$43,021	$45,001
National Institutes of Health			
Training	$ 7,474	$ 7,515	$ 7,515
Research	18,397	21,524	22,835
Total	$25,871	$29,039	$30,350
Social Security Administration			
Income Maintenance	$175,355	$194,597	$208,838
Social and Rehabilitation Service			
Services	$206,918	$240,346	$347,950
Research	897	1,000	1,050
Training	5,424	5,188	5,007
Construction	16,383	6,109	4,886
Other	817	7,978	7,247
Sub-Total	$230,439	$260,621	$366,140
Income Maintenance	97,000	114,000	132,000
Total	$327,439	$374,621	$498,140

Table 1
(Continued)

	1971	1972	1973
Office of the Secretary			
Services	$ 4,270	$ 4,462	$ 4,462
Other	550	750	753
Total	$ 4,820	$ 5,212	$ 5,215
Total, Grants and Services	$377,493	$426,072	$538,113
Total, Income Maintenance	$272,355	$308,597	$340,838
TOTAL, DHEW	$649,848	$734,669	$878,951
2. Activity Summary			
Services	$292,156	$339,157	$451,245
Training	42,110	44,286	44,765
Research	23,013	26,423	27,848
Construction	16,383	6,109	4,886
Other	3,831	10,097	9,371
Sub-Total	$377,493	$426,072	$538,113
Income Maintenance	$272,355	$308,597	$340,838
TOTAL, DHEW	$649,848	$734,669	$878,951

Table 2

U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Obligations for Mental Retardation Programs by Activity Designation
Fiscal Years 1971-1973
(Thousands of Dollars)

ACTIVITY	1971	1972 (Estimate)	1973 (Estimate)
	OFFICE OF EDUCATION		
Services			
Title I, ESEA, Educationally Deprived Children	$39,900	$46,400	$46,400
P.L. 89-313	(26,900)	(32,800)	(32,800)
Title III, ESEA, Supplementary Centers	4,900	4,900	4,900
Education for the Handicapped Act, Part B	10,160	10,160	10,566
Education for the Handicapped Act, Part C, Section 623	860	950	988
Education for the Handicapped Act, Part F	500	700	3,000
Vocational Education Act, Part B	11,500	11,500	11,500
Total, Services	67,820	74,610	77,354
Training			
Education for the Handicapped Act, Part D	10,500	10,500	10,920
Education Professions Development Act	1,400	1,400	1,400
Total, Training	11,900	11,900	12,320
Research			
Education for the Handicapped Act, Part E	1,420	1,600	1,664
Total, Research	1,420	1,600	1,664
Other			
Library Services and Construction Act	69	69	69
Total, Other	69	69	69
TOTAL, OFFICE OF EDUCATION	$81,209	$88,179	$91,407

Table 3

U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Obligations for Mental Retardation Programs by Activity Designation
Fiscal Years 1971-1973
(Thousands of Dollars)

ACTIVITY	1971	1972 (Estimate)	1973 (Estimate)
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION			
Services			
Maternal and Child Health Services			
Maternal and Child Health Services (Section 503 Title V, SS Act)	$ 6,988	$ 6,988	$ 6,988
Crippled Children's Services (Section 504, Title V, SS Act)	6,002	6,002	6,002
Community Environmental Management (P.L. 91-695)	.158	6,749	8,489
Total, Services	13,148	19,739	21,479
Training			
Maternal and Child Health			
Training for Health and Related Care of Mothers and Children (Section 511, Title V, SS Act)	11,200	13,571	13,857
Maternal and Child Health Services (Section 503, Title V, SS Act)	2,767	2,767	2,767
Crippled Children's Services (Section 504, Title V, SS Act)	2,998	2,998	2,998
Mental Health Training (Section 303, PHS Act)	347	347	301
Total, Training	$17,312	$19,683	$19,923

Table 3

ACTIVITY	1971	1972 (Estimate)	1973 (Estimate)
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION (CONTINUED)			
Research			
Maternal and Child Health			
Research Relating to Maternal and Child Health and Crippled Children's Services (Title V, SS Act	$ 1,600	$ 1,600	$ 1,600
Mental Health Research (Section 301, PHS Act)	699	699	699
Total, Research . . .	2,299	2,299	2,299
Other			
Health Care Facilities (Title VI, PHS Act)	2,395	1,300	1,300
Total, Other	2,395	1,300	1,300
TOTAL, HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION	$35,154	$43,021	$45,001

Table 4

U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Obligations for Mental Retardation Programs by Activity Designation
Fiscal Years 1971-1973
(Thousands of Dollars)

ACTIVITY	1971	1972 (Estimate)	1973 (Estimate)
NATIONAL INSTITUTES OF HEALTH			
Training			
Neurology and Stroke Activities	$ 6,216	$ 6,216	$ 6,216
Child Health	1,258	1,299	1,299
Total, Training	7,474	7,515	7,515
Research			
Neurology and Stroke Activities	5,165	5,993	5,993
Child Health	13,232	15,531	16,842
Total, Research	18,397	21,524	22,835
TOTAL, NATIONAL INSTITUTES OF HEALTH	$25,871	$29,039	$30,350
SOCIAL SECURITY ADMINISTRATION			
Income Maintenance:			
Estimated Benefit Payments from Trust Funds	$172,900	$191,750	$206,050
Trust Fund Obligations Incurred to Adjudicate Claims of Beneficiaries	2,344	2,847	2,788
Total, Income Maintenance	175,355	194,597	208,838
TOTAL, SOCIAL SECURITY ADMINISTRATION	$175,355	$194,597	$208,838

NATIONAL INSTITUTES OF HEALTH
SOCIAL SECURITY ADMINISTRATION

Table 5

U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Obligations for Mental Retardation Programs by Activity Designation
Fiscal Years 1971-1973
(Thousands of Dollars)

ACTIVITY	1971	1972 (Estimate)	1973 (Estimate)
SOCIAL AND REHABILITATION SERVICE			
Services			
Rehabilitation Services			
Grants to States, Sec. 2, VR Act	$ 65,390	$ 78,400	$ 89,700
Innovation Grants, Sec. 3, VR Act	28	0	0
Expansion Grants, Sec. 4(a)(2)(A), VR Act	108	100	100
Facility Improvement Grants, Sec. 13, VR Act	3,390	3,800	3,800
Services for the Developmentally Disabled			
Formula Grants for the Developmentally Disabled, (P.L. 91-517, Sec. 131)	3,769	17,206	13,832
Hospital Improvement, PHS Act, Sec. 303	6,598	5,456	3,528
Initial Staffing (P.L. 88-164, Sec. 141)	8,272	8,472	3,920
Project Grants, VR Act, Sec. 4(a)(1)	5,063	5,912	7,070
Social Services, SS Act[1/]	NA	NA	NA
Medical Assistance, Title XIX, SS Act[2/]	114,300	121,000	226,000
Total, Services	$206,918	$240,346	$347,950
Research			
Research and Demonstrations, Secs. 4 & 7, VR Act	$ 502	$ 600	$ 650
Social and Rehabilitation Activities Overseas (Special Foreign Currency Program)	395	400	400
Total, Research	$ 897	$ 1,000	$ 1,050

Table 5

ACTIVITY	1971	1972 (Estimate)	1973 (Estimate)
SOCIAL AND REHABILITATION SERVICE (CONTINUED)			
Training			
Services for the Developmentally Disabled VR Act, Sec. 4(a)(1)	$ 502	$ 600	$ 650
Hospital Improvement, PHS Act, Sec. 303	3,642	3,735	3,982
Research and Training Centers, VR Act, Sec. 4(a)(1)	1,039	553	125
Total, Training	$ 5,424	$ 5,188	$ 5,007
Construction			
University-Affiliated Facilities for the Developmentally Disabled	$ 1,591	$ 31	-0-
Developmental Disabilities Formula Grant	14,792[3]	6,078	4,886
Total, Construction	$ 16,383	$ 6,109	$ 4,886
Income Maintenance			
Grants to States for Public Assistance - Aid to Permanently & Totally Disabled	$ 97,000	$114,000	$132,000
Other			
Services to the Developmentally Disabled University-Affiliated Facilities Demonstration Grants (P.L. 91-517, Title II)		$ 4,250	$ 4,250
Formula Grants for Developmentally Disabled (Planning & Administration, P.L. 91-517, Sec. 131)	817	3,728[4]	2,997[4]
Total, Other	$ 817	$ 7,978	$ 7,247
SOCIAL AND REHABILITATION SERVICE			

Table 5

ACTIVITY	1971	1972 (Estimate)	1973 (Estimate)
SOCIAL AND REHABILITATION SERVICE (CONTINUED)			
Total, Grants and Services . . .	$230,439	$260,621	$366,140
Total, Income Maintenance . . .	97,000	114,000	132,000
TOTAL, SOCIAL AND REHABILITATION SERVICE	$327,439	$374,621	$498,140
OFFICE OF THE SECRETARY			
Services			
Office of Child Development - Head Start	$ 4,270	$ 4,462	$ 4,462
Other			
Office of Mental Retardation Coordination	(110)	115	118
President's Committee on Mental Retardation	550	635	635
TOTAL, OFFICE OF THE SECRETARY	$ 4,820	$ 5,212	$ 5,215

1/ States obligate funds under Titles IV and XVI of the Social Security Act for social services to mentally retarded persons. However, present reporting systems do not permit an estimate of the amount of funds.
2/ Amounts reported are estimates based on FY 1970 data from 16 states reporting Social Security Act, Title XIX funds claimed for mental retardation.
3/ Includes funds appropriated in prior fiscal years.
4/ These amounts represent estimates of funds used by the states for planning and administration.

SOCIAL AND REHABILITATION SERVICE
OFFICE OF THE SECRETARY

Mental Retardation Programs of The Department of Health, Education, and Welfare

Each year the Office of Mental Retardation Coordination prepares a detailed report on the Department's mental retardation programs for submission to the House of Representatives Subcommittee on Appropriations. A copy of the 1972 report entitled "Mental Retardation Programs of the Department of Health, Education, and Welfare" is available free of charge upon request from the Office of Mental Retardation Coordination, Department of Health, Education, and Welfare, 330 Independence Ave., S.W., Washington, D.C. 20201.