programs for the handicapped

Secretary's Committee
on Mental Retardation

August 9, 1971 71-7

SELECTED MATERIAL ON
SOCIAL SECURITY PROGRAMS
in the
UNITED STATES OF AMERICA
and
ABROAD
AFFECTING
the
MENTALLY RETARDED

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U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Secretary's Committee on Mental Retardation
Washington, D.C. 20201

SOCIAL SECURITY PROGRAMS
in the
UNITED STATES OF AMERICA

Introduction

The basic purpose of the social security program is to provide cash benefits to replace, in part, earnings that are lost to individuals and families when earnings stop or are reduced because the worker retires, dies, or becomes disabled, and to provide health insurance protection to persons 65 and over. The program is contributory, it is self-supporting, benefits are wage-related, and entitlement to benefits is an earned right.

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.

Mental deficiency is a major factor in more than 65 percent of cases involving dependents or survivors who have been continuously disabled since childhood. It is the primary diagnosis in about half of all childhood disability cases. In fiscal year 1970, an estimated 168,000 mentally retarded adults disabled in childhood and 8,000 mentally retarded workers received $156 million.

The number of mentally retarded children under age 18 who receive payments as dependents of retired, disabled, or deceased workers is unknown, since their benefits are payable regardless of disability.

Under social security's "Childhood Disability" provisions, lifetime monthly payments can be made to a person age 18 or over who has been disabled by mental retardation--or other impairments--since childhood. In many cases, the monthly benefits enable the retarded childhood disability beneficiary to be cared for at home instead of in an institution. Furthermore, as more and more retarded people outlive their parents, the program offers reassurance to fathers and mothers who know that financial help for their disabled child will be forthcoming even after their death. (About half of the childhood disability beneficiaries are over 35 and 25 percent of them are over 45).

If the parents are dead, a relative who has demonstrated a continuing interest in the beneficiary's welfare, a welfare agency, a state institution, 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.

During 1970, the Social Security Administration launched a new program instituting 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 following article entitled "Somebody Cares" describes the program.

SOMEBODY CARES*

"The patients were very pleased . . . It was the first time some had had visitors in years. One patient smiled--his first reaction of any type in a long time . . . Others became interested in their environment and looked for 'good' clothing to wear for the visit . . . Still others now feel that someone does care about them."

These are some of the comments made by the superintendent of a State Mental Hospital after the visit of two Social Security employees. The favorable effects of the visit were a byproduct of the Social Security Administration's new Onsite Review Program. Established after a successful pilot study last year, the program is a new approach to representative payee accounting for beneficiaries who are mentally ill or mentally retarded in State mental institutions.

SSA policy is that every adult beneficiary should be paid directly unless he has been found incapable of managing his benefits or protecting his interests. Where this is the case, a representative payee is selected to receive cash benefit payments on his behalf. This is where State mental institutions come into the picture.

Although there are people suffering from mentally handicapping conditions in institutions who receive their social security benefits directly (usually for therapeutic reasons), there are some 100,000 others for whom State mental institutions act as representative payee. Before appointing such an institution as payee, the possibility of having someone with a strong interest in the personal welfare of the beneficiary act as representative payee is first thoroughly investigated. This person could be a legal guardian, relative, or friend. If no such individual can be found, the institution with custody of the beneficiary is usually named.

As payee, the State mental institution has the responsibility to follow an individualized approach in the use of social security benefits for each beneficiary. From the monthly benefit check, the institution must first pay for the beneficiary's current needs.

Customary charges for institutional care and maintenance are considered part of the current needs of a beneficiary, and usually part of the patient's monthly check is used to pay some of the charge.

Generally, the institution uses part of a patient's social security payment for his day-to-day personal needs, and SSA has always encouraged this type of expenditure. In most hospitals, a personal spending account is maintained for each beneficiary. Small purchases, made by or for him are applied against the balance of his account. If the social security recipient wants a more expensive item - a radio, for example - he will probably need special permission from the hospital staff to buy the item, or have it purchased for him and charged to his account.

Most hospitals have canteens at which patients may buy candy, tobacco, or various personal items. Some hospitals permit patients to carry cash for such purchases, while others may give the patient a coupon book for his canteen transactions. Many institutions believe that the cash method is preferable since it resembles the outside world more closely.

The Social Security Administration has a continuing responsibility to make sure that monthly benefits due a beneficiary are treated as his individual income rather than as a payment to the institution for care and maintenance. In line with this responsibility, all institutions have been required to submit an annual accounting report to SSA for each beneficiary for whom they are serving as payee.

These reports were not satisfactory as a means of evaluating the overall performance of the institutions in their roles as representative payee. Time and cost factors involved in preparing the paper reports were high; and, at the same time, the reports gave no more than a summary of money spent by the institutions on behalf of beneficiaries. From these summaries, SSA could not always determine whether the beneficiary was getting the personal items that are essential to everyone's daily life. In addition, there was no easy way to find out how any particular State was, on balance, managing its payee responsibilities. This meant that SSA could not give State officials any overall information concerning our reaction to their use of individual benefits.

The new Onsite Review Program, in which 24 States have thus far agreed to participate, calls for replacement of the annual accounting reports method with a personal visit to State institutions that serve as representative payee for large numbers of beneficiaries. A team of two SSA employees will visit these institutions once every 2 years. Visits last from a few days to 3 weeks depending on the beneficiary population in the institution.

When the team arrives at a mental hospital, its members meet with the superintendent or his designee, his assistants for the administrative and clinical areas, and his chief of accounting, social services and nursing. At this meeting, the team finds out what standard policy and procedural guidelines are used by the institution in its role as representative payee.

The rest of SSA team's visit is devoted to gathering information about specific beneficiaries, since the idea behind onsite review is to get a general picture of how beneficiaries' payments are being used in the light of their individual circumstances and needs. Not all social security recipients in the institution become involved. A representative sample of beneficiaries is selected by SSA Central Office staff.

The team looks at fiscal records to see how and how much of the beneficiaries' money is being spent. Are there entries showing that money was spent on personal items, for instance? (The onsite reviews are showing that institutions vary greatly in the way they handle social security benefits).

Once the records are examined, the team interviews various hospital staff members, including nurses and ward personnel, in order to amplify what the records show.

SSA team members also talk briefly with each of the beneficiaries unless such a visit isn't medically feasible. They ask them about their activities and spending money, describe their appearance, and report any comments or requests they may make.

Then, all the teams' findings are reported back to SSA Central Office staff for evaluation. When the analysis is finished, a summary report is prepared for State use. This is then followed up by a meeting with State officials and Regional SSA staff, to discuss the findings and to seek improvements where indicated. Good features, as well as suggested improvement on the part of the State and SSA are brought up.

The onsite review approach has been developed by SSA Central Office staff. Within the next year, the major responsibility for continuing the onsite review program will be transferred to Regional staff. As the decentralization takes place, Central Office staff will be moving into the development of other policy-evaluation activities, especially in the area of representative payment.

Once all 50 States come under the new onsite review program, some 100,000 accounting reports each year will be eliminated. The elimination of this paperwork mountain represents one of the most tangible assets of the new program for both SSA and the State mental institutions. In addition, the new program is giving SSA a more definitive means of meeting its responsibilities to beneficiaries.

There are, however, intangible results that are almost as important. To the patient who smiled for the first time in years, that visit by a SSA employee meant a lot. But the benefits reaped from these visits aren't one-sided.

Commented one SSA reviewer: "This experience was particularly enlightening for someone from a payment center. Too often we tend to forget that each action we take on a folder affects the life of a real person. When you go out into the hospital and see the kind of people who are dependent on social security for their sustenance, it makes your judgment a little more humane."

Looking at his visit in still another way, one SSA reviewer stated: "We found the onsite review interesting and challenging . . . Aside from the relief of preparing the annual accounting reports by the institution's personnel, which was accepted heartily, our sample beneficiary audit may have stirred some interest in the staff as to the use of social security funds for their beneficiaries. We feel a periodic review, such as this, brings home to the hospital staff that SSA continues to have an interest in our beneficiaries many years after the issuance of the first check."

Initial contacts with State officials to explain onsite review and to request their participation are made by Regional SSA staff. After that, the Central Office, as the lead component in the program, sets up the arrangements for carrying out the reviews and developing the final reports.

Experience with the onsite review program is demonstrating that the personal review approach works. As the superintendent of a training school for the mentally retarded wrote to a SSA official: "I have served as payee for Social Security beneficiaries at the Training School for approximately 10 years. I want to compliment you on the change from yearly audits to onsite reviews . . I am sure that this change is going to save a great deal of bookkeeping, and, at the same time, improve the Social Security program at this institution."

* Minor modifications have been made by SCMR with the assistance of OASIS editorial staff.

SOCIAL SECURITY ABROAD

Mental Retardation in Four Countries*

This study on mental retardation was originally prepared by the Office of Research and Statistics, SSA, for a special task force on mental retardation established by the Secretary of Health, Education, and Welfare.

The four countries studied - Sweden, the Netherlands, the United Kingdom, and the Union of Soviet Socialist Republics - were chosen because they have often been cited by foreign observers, most notably by study teams of the President's Panel on Mental Retardation, as having public programs for mental retardation with desirable features.

Brief descriptions are given below of the social security programs in these countries as they relate to the mentally retarded, followed by an outline of medical services that can also be considered as a form of social security since all four countries have national health schemes. To convey a more nearly comprehensive impression of the position of the mentally retarded, some of the other public programs for the mentally retarded in the fields of welfare, education, and rehabilitation have also been discussed.

To provide some perspective it is probably worthwhile to give a brief description of those provisions of the social security program in the United States that extend benefits to the mentally retarded. The largest category of the mentally retarded beneficiaries qualifies under the amendments to the Social Security Act that provide for payments to adult persons, disabled before age 18, who are the children of deceased insured workers or workers entitled to disability or retirement benefits. Eligibility is also predicated on satisfying the general definitions of disability in the Social Security Act: Inability to engage in any substantial activity because of any medically determinable physical or mental impairment that has lasted or can be expected to last for a continuous period of at least 12 months or that can be expected to result in death.

As of December 1968, there were 243,000 such beneficiaries in all categories of disability receiving a total of about $15 million a month. The average benefit was $61.80. An estimated 153,000 of these disabled beneficiaries were mentally retarded.

In addition to these adult beneficiaries (aged 18 or over), an indeterminate number of mentally retarded children receive payments as dependents of retired, disabled, and deceased workers. These children, until they reach age 18, would be eligible for benefits regardless of disability.

A few of the mentally retarded obtain benefits under other provisions of the social security program. Under the provision that has made benefits payable since February 1968 to disabled widows and widowers (at a reduced rate), mental retardation accounts for the primary diagnosis of about 2 percent of such beneficiaries. Among disabled-worker beneficiaries, somewhat less than 1 percent have a primary diagnosis of mental retardation.

The social security program now also provides for referral of disabled beneficiaries to State vocational rehabilitation agencies for possible rehabilitation services. Under this feature, the State agencies are reimbursed from the social security trust funds for the cost of services extended to those receiving benefits because of disability. A sum equal to 1 percent of all disability benefits paid out under the program in the preceding year can be made available for these purposes. Persons referred for vocational rehabilitation services under this provision include disabled-worker beneficiaries, childhood-disability beneficiaries, and disabled widows and widowers.

SOCIAL SECURITY BENEFITS

Sweden

Several years ago Sweden inaugurated a special allowance for families with severely handicapped children - now about 3,420 kronor (one U.S. dollar equals 5.2 kronor) a year. Approximately 0.16 percent of the children under age 16 receive such benefits for mental retardation. This group represents roughly one-half the severely retarded group.

In addition, a regular children's allowance of 900 kronor a year is granted to all children under age 16. Thus, in total, the severely retarded child receives about $900 per year or about one-fifth of the wages of the average worker in manufacturing. When the mentally retarded child reaches age 16, he is eligible for a disability pension of about $1,000 per year.

Netherlands

The Netherlands has a system of family allowances that are paid to all children under age 16, with a few exceptions. For invalids (including the mentally retarded), the allowance is payable to age 27.

The benefits amount to 37.44 guilders (one U.S. dollar equals 3.6 guilders) per month for families with one child. The rate rises for each additional child up to the eighth. The maximum amount, paid for the eighth and each subsequent child, is 70.2 guilders (slightly more than one-eleventh of the average wage in manufacturing).

In general, however, in trying to ease the burdens borne by the mentally retarded and their families the Netherlands seems to have developed direct social security assistance less extensively than medical and rehabilitative programs, some of which are described below.

United Kingdom

Family allowances are provided for families with at least two children. They amount to 18 shillings (1 shilling equals 12 cents) a week for the second child and 1 pound for the third and each subsequent child. Allowances normally stop at age 15 but continue until age 16 for the mentally retarded. At age 16 the mentally retarded without personal resources of income are eligible for allowances under the national supplementary benefits system of about 5 pounds a week ($12 or slightly more than one-fourth of the average worker's wage in manufacturing).

Union of Soviet Socialist Republics

Regular family allowances exist in the USSR, but they are low and are payable only to families with four or more children and, even then, the eligible children must be under age 5. The rules are more lenient for unwed mothers. The allowance is 4 rubles a month for the fourth child and rises progressively to 15 rubles for the 11th and each additional child. (At the official Russian exchange rate, 1 ruble equals $1.11).

According to several writers on the Soviet Union, the family or relatives caring for the mentally retarded at home are given generous grants at the discretion of the local clinical specialist. No figures are available on the exact size of these grants, however.

In addition, since 1967, the mentally retarded who can be considered to be completely incapacitated from childhood have been entitled to 16 rubles a month as a disability pension upon reaching adulthood. (According to official Russian statistics, monthly cash earnings of wage earners in 1968 averaged 112.5 rubles).

MEDICAL BENEFITS

Both the United Kingdom and the Soviet Union have universal medical care systems with services that are provided virtually free of charge. Several writers on mental retardation who have visited the USSR have noted the relatively large number of psychiatrists to which the mentally retarded have access and the extensive system of diagnostic clinics for identifying and treating mentally retarded children.

In the USSR, where residential care is necessary for the mentally retarded child, parents must contribute to the upkeep of the institutionalized children. The schedules of charges in 1965 are shown below:

(In rubles)

Monthly earnings	Contributions per month
30-40	8
70-80	25
100 or more	40

Unmarried mothers, mothers with more than three children, and parents who are old-age pensioners or disabled are exempt from these fees. Parental contributions, in any case, cease after the child reaches age 18.

In Sweden, there is also universal medical coverage under the national health insurance scheme, but the individual normally has to pay a fourth of the doctor's fees himself. Ward hospital care is free. Preschool-age children are entitled to free care at child welfare centers.

In the Netherlands in recent years a little more than 70 percent of the population has been covered by subsidized health insurance. However, municipal programs have provided free diagnostic services and comprehensive health care to children, as well as to the mentally retarded who have completed special schools or have been released from institutions. Efforts are being made to improve diagnostic and medical care facilities directed at children of preschool age.

As of 1962, parents in the Netherlands with income over 12,000 guilders a year and 50,000 guilders in capital assets were required to reimburse municipalities by as much as 7-15 guilders a day for their children over 21 in institutional care. These charges have presumably been eliminated since the national insurance scheme was expanded on January 1, 1968, to include universal coverage for prolonged treatment for the handicapped, including the mentally retarded.

RESIDENTIAL CARE AND EDUCATION OF CHILDREN

Sweden

Swedish authorities estimate that about 0.8 percent of children of school age are mentally retarded. This group roughly corresponds to the number of children with an IQ less than 70. Those with an IQ of 70-85 are not considered retarded but are taught in regular schools in "slow learner" classes instead.

Under the Swedish approach, every effort is made to keep children with their parents if possible. To make it more feasible for parents to keep even the most severely retarded child at home the special children's allowance mentioned previously was instituted.

About half of the mentally retarded children are institutionalized, and about 10 percent of these are in hospitals or in residential care for the mentally retarded. The others are in 5- or 7-day institutions where the emphasis is on educating them to the extent of their abilities. In rural areas, because of the relatively sparse population and the correspondingly great distances to the closest facilities for the mentally retarded, it has been necessary to institutionalize more children than would otherwise be considered ideal.

Netherlands

Estimates of the proportion of mentally retarded in the Netherlands population correspond fairly closely to those for the United States: 3 percent of the school-age population is categorized as mentally retarded. Children with an IQ of roughly less than 80 are considered retarded. The cut-off point for another category of retarded individuals is set at 60.

In 1964 about 1.7 percent of the children of school age were in special schools for the retarded. One in 5 of these was in the IQ 60 or below category. Roughly 1 percent of the children considered retarded were in the regular schools, normally in regular classes. These children, most of whom would be in the less retarded category, seem to be able to adjust to the working world upon leaving school. The problem of placing them in competitive employment has been eased by a national labor shortage of long duration and the assistance of an elaborate public employment service.

Of the 330 special schools in 1964 approximately 300 were day schools and the remainder were residential facilities. Less than a third were public schools run by the municipalities. The others were either private or denominational, liberally subsidized by the Government. In 1960, the Ministry of Education's budget allotted funds to special education for the mentally and physically handicapped that were nearly one-tenth of the total amount expended for ordinary education (40.4 million guilders, compared with 456.8 million guilders). This high proportion is an indication of the expensive nature of good facilities for the education of the mentally retarded.

Training for the retarded emphasizes mastering of motor skills, and academic learning is generally confined to imparting limited concepts such as time, use of money, and mastery of simple oral expression. Heavy reliance is placed on learning through manipulating objects and teaching equipment of the Montessori type.

United Kingdom

Most medical authorities consider 2 percent of the population to be mentally retarded. In 1964 the number of children actually attending special schools for the subnormal was 41,000 (0.6 percent of all school-age children). The estimated proportion of school-age children who required places in the special schools was 0.8 percent. These children usually have IQ's between 50 and 75. In line with the British attempt to create new patterns of care for the mentally retarded that emphasize integration in the community at large, there is an attempt to have as few boarding schools as possible.

There are few special classes for slow learners and the less severely retarded in the ordinary schools. Some authorities believe, however, that many of these children in the regular schools could also benefit from special help.

For those children whose mental abilities are too meager even for the special schools, there is a system of training centers. A few years ago, it was estimated that the capacity of these institutions had to be expanded to provide placement for 3 individuals per 1,000 in the population, or a total of 20,000 in England and Wales. This capacity was actually reached in 1968. Now, however, estimates of the real need have been revised upward along with recommendations for improving the training given and upgrading the qualification of the personnel.

Children usually remain in junior training centers from age 5 to age 16. Many are then placed in senior training centers where an attempt is made to prepare them for work placement either in industry or in sheltered workshops.

Union of Soviet Socialist Republics

Russian authorities estimate the number of mentally retarded to be no more than 1 percent of the total population. Retarded children in the USSR are considered as an educational problem rather than a health problem except for those in the most afflicted category who are the special responsibility of the Health Ministry. A number of writers who have observed the Russian program have emphasized the good quality of arrangements for preschool diagnosis and treatment.

Almost all children receive a 1-year trial in regular classes once they reach school age. Those children who do not learn quickly enough are placed in special remedial classes of 10-15. From there they may be further transferred to special schools where they are kept until they reach age 18. During their last 2 or 3 years of education they are given training specifically directed toward preparing them for employment.

The special schools, run on a daily basis in urban areas and on a boarding basis in rural areas, place particular emphasis on self-help. Visitors to the Soviet Union have noted that the classrooms contain a large proportion of severely retarded pupils and have concluded that the Soviet Union has been successful in imparting a higher level of education to this group than has traditionally been considered feasible in other countries. Some of the success in this regard has been attributed to the heavy reliance on highly trained "defectologists" to administer to the needs of the more severely retarded. The defectologist in the USSR is a qualified teacher who has completed advanced studies in the special problems of the mentally retarded and receives a salary equivalent to that of a physician.

The Russian system ideally considers it advisable to remove the mentally retarded child from his home at the earliest possible age and place him in an institution until he reaches adulthood. It is felt that in the institution he can be given round-the-clock training and be trained to the limit of his capacities.

Although the facilities for the mentally retarded that have been observed by foreign visitors appear to be of uniformly high quality, they do not yet seem to exist in numbers great enough to accommodate more than a portion of those who could benefit. Official Russian statistics show that only about 0.6 percent of school-age children are in special schools. These schools are attended not only by children with mental problems of all types but also by the physically handicapped. The shortage of facilities seems to be particularly acute in rural areas, but the problems of adjustment for the mentally retarded in an agricultural setting are not so great as in the cities.

FACILITIES FOR THE MENTALLY RETARDED OF POST-SCHOOL AGE

Sweden

A recent survey of the mentally retarded in their early twenties indicates that, among school-age children, about one-half are in institutions. Even among the institutionalized, however, a majority are able to engage in gainful employment provided by sheltered workshops. Of those outside institutions, slightly less than half are engaged in competitive work and need no special supervision. About an equal number work in sheltered workshops, with some of them living in hostels. A few of those not in institutions attend vocational schools run by the larger cities for the mentally retarded up to the age of 23.

Sheltered workshops now employ about 1,000 (approximately 2 per 10,000 of the adult population) of the mentally retarded. About half of these are ultimately rehabilitated into regular employment and go off the rolls of the mentally retarded.

In addition to those sheltered workshops operated by municipalities and counties, a number are run by private organizations. These private institutions are, however, heavily subsidized by public funds. Swedish authorities consider the sheltered workshop program highly successful and plan to expand it considerably.

In recent years, Sweden has also tried to develop a network of hostel-type residential facilities where the adult mentally retarded can reside with a minimum of supervision while they work in competitive employment or in sheltered workshops. Medical officials believe that no more than 10 percent of the adult mentally retarded need be confined in hospitals if other types of care such as hospital outpatient arrangements and hostels are established in adequate numbers. The proportion now hospitalized in Sweden has been brought down to 17 percent of the adult mentally retarded.

Netherlands

The sheltered-workshops network stands out as the most successful feature in the country's progress toward rehabilitating the mentally retarded. Their number has been growing rapidly. In 1964, there were 191 - about three times as many as there were 10 years earlier. The number of mentally retarded persons who were employed in these workshops was 6,000 in 1961 or 75 per 100,000 of adult population. Their IQ's generally run about 45-65.

As far as possible the workshops emphasize preparation for return to industry. In practice, however, the number passed on to regular industry does not seem to be high, probably because only the less trainable are accommodated in the workshops. One manager of a workshop for 90 persons estimated that annually about 5 percent of his workers are able to take on regular employment elsewhere. Authorities believe that even though most of the workers never become competitively productive from a purely economic point of view, the therapeutic value of such employment should not be underestimated.

The Ministry of Social Affairs and Public Health subsidizes the workshops up to 75 percent of wages and a considerable amount of the costs incurred in business operations.

Workers are paid by a complicated point system with the maximum wage set at the minimum wage prevailing in normal industry. In 1965 this was 100 guilders per week. Workers who cannot achieve one-third of the normal working level are paid on a different, lower salary scale.

American observers of Dutch workshops have come to the conclusion that the mentally retarded can perform much more complex operations than they had previously thought possible. It is reported, for example, that power machines are operated even by workers with IQ's below 50.

In 1964 the Hague area had about 0.09 percent of its population in hospitals for the mentally retarded. This figure was roughly equivalent to the rate in the United States and was somewhat higher than that for the Netherlands as a whole.

The Dutch have also set up group homes with minimally sheltered living situations. In 1962, it was estimated that 8,000 of the mentally retarded were placed in these facilities. In 1970, it is expected that there will be 13,500 or a rate of 2 per 1,000 of adult population.

United Kingdom

Although the British have pioneered in the field of rehabilitation, it is only recently that attention has been directed toward the problems of the mentally retarded. As a result, rehabilitation organizations provide assistance only to limited numbers of the mentally retarded. In 1962, there were some 12,000 disabled persons of all types in sheltered employment. During the same period, industrial rehabilitation units, which conduct training courses for the disabled that average about 8 weeks in duration, accommodated another 11,000 people over the course of a year. Only a small portion of these are mentally retarded.

Recently, another type of institution for helping the retarded has grown rapidly. These are the senior training centers that by the end of 1967 were providing training for about 30 percent of the mentally retarded over age 16 in the care of local authorities. The number enrolled in these centers grew from 6,987 in 1960 to 22,321 in 1968.

It is assumed that the proportion receiving training in the senior training centers will increase as those who had training as children that can be successfully continued and broadened in later years reach maturity. Nonetheless, it is felt that despite rapid improvement, there is still an unmet need for reaching and helping the older adult.

In recent years approximately 65,000 mentally retarded persons (or about 20 per 10,000 of the overall adult population) have been confined to hospitals. The United Kingdom has come to rely increasingly, however, on other institutions such as hostels and similar forms of residential accommodations. By the end of 1967, such arrangements had been made for about 5 percent of the mentally retarded not residing in hospitals.

Although the number of hospital beds under present conditions is considered to be inadequate even in the best-served areas, some writers think that no more than 74 beds per 100,000 of the general population would be needed if other facilities were adequate. This estimate is in general agreement with the number that Swedish officials consider necessary under optimum conditions.

Another program with promise aims at providing short-term care for the severely retarded to relieve their families for brief intervals of the problem of caring for them. Families with a mentally retarded individual are visited once every half year by mental welfare officers who offer advice and, when it is feasible, assistance. Efforts are being made to improve this service since currently only 24 percent of the parents concerned consider the program adequate as presently constituted.

Union of Soviet Socialist Republics

The mentally retarded in the Soviet Union complete their formal education at age 18. The Russians state that most of them are then employed in industrial enterprises in their own communities and are returned to their families. If the families are not able to care for them, they proceed to young adult homes where some receive additional training and others lead more or less normal lives, residing at the institution but holding down full-time jobs. Emphasis is placed on work as therapy. Even most of the severely retarded work in sheltered workshops at simple tasks such as folding cardboard boxes.

No precise figures are available on the exact arrangements for the adult disabled. It would seem, however, that the vast majority reside either with their families or in special homes. Analysts of Russian medical data estimate that approximately half as many beds in psychiatric hospitals are occupied by the mentally retarded as in the United States (in relation to the total population).

Like the three Western countries studied, the Russians seem to tend toward deemphasizing hospital facilities for the mentally retarded in favor of educational facilities and integration in the community at large.

*From Social Security Bulletin, May 1970. Minor modifications have been made by SCMR. The Social Security Bulletin is for sale by Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402. Price: $4.00 a year in the United States, Canada, and Mexico; $5.00 in all other countries; single copies 35 cents.

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CHILDHOOD DISABILITY BENEFICIARIES

The following tables contain selected data on childhood disability beneficiaries in calendar year 1967. Their disabilities began before they reached age 18. All were dependent sons and daughters of retired, disabled, or deceased insured workers. These tables were selected from Social Security Disability Applicant Statistics, 1967, published by the Social Security Administration in May 1971.

Childhood disability allowances: Number and percentage distribution by age and sex, 1967

Age on birthday in 1967	Total		Male		Female	
	Number	Percent	Number	Percent	Number	Percent
Total	20,400	100.0	11,532	100.0	8,868	100.0
18-24	10,308	50.5	5,983	51.9	4,325	48.8
25-29	2,644	13.0	1,509	13.1	1,135	12.8
30-34	2,339	11.5	1,295	11.2	1,044	11.8
35-39	2,193	10.8	1,184	10.3	1,009	11.4
40-44	1,392	6.8	746	6.5	646	7.3
45-49	677	3.3	355	3.1	322	3.6
50 and over	847	4.2	460	4.0	387	4.4

Childhood disability allowances: Number and percentage distribution by education and sex, 1967

Highest grade of school completed	Total		Male		Female	
	Number	Percent	Number	Percent	Number	Percent
Total	20,400	100.0	11,532	100.0	8,868	100.0
No schooling	6,845	33.6	3,944	34.2	2,901	32.7
4th grade or less ...	2,263	11.1	1,318	11.4	945	10.7
5th-7th grades	2,160	10.6	1,218	10.6	942	10.6
8th grade	1,316	6.5	717	6.2	599	6.8
9th-11th grades	2,044	10.0	1,159	10.1	885	10.0
12th grade	1,164	5.7	572	5.0	592	6.7
1 or more years college	228	1.1	135	1.2	93	1.0
Ungraded special classes	1,872	9.2	995	8.6	877	9.9
Unknown education ...	2,508	12.3	1,474	12.8	1,034	11.7

Childhood disability allowances: Number and percentage distribution by age and mobility status, 1967

Mobility status	Age on birthday in 1967									
	Total		18-24		25-34		35-44		45 and over	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Total	20,400	100.0	10,308	100.0	4,983	100.0	3,585	100.0	1,524	100.0
Institutionalized 1/ ...	5,184	25.4	2,374	23.0	1,293	25.9	997	27.8	520	34.1
Hospitalized 2/	152	.7	91	.9	28	.6	17	.5	16	1.0
Housebound	1,520	7.5	703	6.8	415	8.3	299	8.3	103	6.8
Ambulatory outside the home -										
With help	5,001	24.5	2,521	24.5	1,252	25.1	911	25.4	317	20.8
By self	8,543	41.9	4,619	44.8	1,995	40.0	1,361	38.0	568	37.3

1/ Disabled person was confined to an institution i.e. mental, tuberculosis, or chronic disease hospital, soldiers' home, etc.

2/ Disabled person was a patient in a general hospital

U.S. DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
SECRETARY'S COMMITTEE ON MENTAL RETARDATION
WASHINGTON, D.C. 20201

Childhood disability allowances: Ten primary diagnoses occurring most often among beneficiaries

Primary diagnosis	International code	Number	Percent	Cumulative percent
	Total			
1. Mental deficiency	325	10,910	53.5	53.5
2. Cerebral spastic infantile paralysis	351	1,881	9.2	62.7
3. Epilepsy	353	1,433	7.0	69.7
4. Schizophrenic disorders (dementia praecox)	300	1,390	6.8	76.5
5. Mental deterioration and certain other psychoses of unspecified etiology.	309	690	3.4	79.9
6. Chronic brain syndrome ...	328	560	2.7	82.7
7. Late effects of acute poliomyelitis	081	280	1.4	84.0
8. Congenital cataract and other congenital malformations of nervous system and sense organs.	753	207	1.0	85.0
9. Deafness	398	189	.9	86.0
10. Certain diseases of muscle, tendon, and fascia	744	154	.8	86.7

GPO 915-031