DEMOGRAPHIC STUDIES OF RESIDENTIAL FACILITIES FOR THE MENTALLY RETARDED:
An Historical Review of Methodologies & Findings

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INTRODUCTION

The first permanent residential facility exclusively for mentally retarded persons in the United States was founded in Massachusetts in 1848. Housed in a wing of a school for the blind at its inception, the experimental school, as it was called, was quickly deemed a success and a separate facility was constructed by that state three years later. Within a quarter of a century several states had constructed institutions for the "idiotic and feeble-minded" and, to borrow the words of a director of one of these early facilities, at ever increasing rapidity, other states were "falling in line." It was not long before institutions for the care of the mentally retarded were found in most states. Like public schools and public transport they were perceived as doing their part to support the functioning of America as a nation.

It would be difficult to separate the general interest in the mentally retarded in this country in the nineteenth and early part of the twentieth century from the movement to place persons so perceived in institutions. The American Association on Mental Deficiency (AAMD) spent its first three decades (1876 - 1906) as the Association of Medical Officers of American Institutions for Idiotic and Feeble-minded Persons. In time, however, the interest in those mentally retarded persons who were not in institutions was extended beyond the desire to find ways to place them there. Parallel systems of education and training developed within this century with a focus on community treatment, and by the middle of the twentieth century these became the dominant force in the programs provided for mentally retarded persons.

As Sloane pointed out in his Presidential Address to the AAMD in 1963 and as Wolfensberger (1975) carefully documented more recently, the place of the institution in American society has undergone a number of philosophic transformations since the mid-nineteenth century. In the past two decades descriptions of the social realities of institutions, powerfully done by Goffman

(1963) and several other observers, have sensitized Americans to the abnormal social environment of total institutions and have caused service providers to seek alternatives to such facilities. Still, even today many public institutions for the mentally retarded continue to function, serving as the primary residence for approximately 140,000 persons for whom alternatives to institutional living have not yet been provided.

For nearly a century government agencies or non-governmental groups, fully or partially aided by federal financial support, have conducted studies of the demographic characteristics of residents in public and private residential facilities for the mentally retarded. The purpose of this volume is to review those studies. Even though social conditions leading to the growth and, in the last decade, the decline in the use of institutions are woven into this review, it is not the author's primary intent to write a summary of the institutionalization and deinstitutionalization trends and processes. For this reason the volume is divided into chapters according to the nature of the studies cited and not on what might be seen as salient chapters in the sociocultural history of American institutions and other residential facilities for mentally retarded people. As the reader may note, however, there is a rather strong relationship between the methods and care with which these studies were conducted and what other writers have outlined as general philosophic periods in the development of residential facilities for the mentally retarded.

In developing this paper, the author has tried, as much as possible, to let the words of the persons conducting the studies explain their methods, perspectives and rationales for their work. As part of this attempt, throughout the paper, diagnostic terminology applied by the persons conducting the enumerations has been used. Because of this, the paper is replete with terms such as "idiotic," "feeble-minded," "imbecilic," etc.. Such terms are today not only passe, but often considered disparaging. In using the language of the times there is certainly no intent to be degrading of these persons. Neither, it is hoped, will the use of these terms be seen as an attempt to paint the authors of these censuses as insensitive or ignorant. Since 1840, terminology applied to those now referred to as "mentally retarded" has passed through several stages. These persons have been referred to over the years as "idiots," the "feeble-minded," "mental defectives," and "retardates." In time each of these terms has come to take on a sufficiently negative

symbolism to cause workers in the field to seek a newer, and for a while at least, a more palatable term. In retrospect it is clear that one generation's euphemism has tended to become the next generation's derogation. The author hopes that those reading these terms in this report will find nothing more in them than that which was intended. The omission of quotation marks after the first major use of a term has been done in the same spirit, with the additional purpose of making readable what would otherwise be a seriously cluttered text.

ENUMERATIONS OF IDIOTIC AND FEEBLE-MINDED PERSONS WITHIN THE DECENNIAL CENSUS, 1840-1890

With the 1840 census, the United States government made the first attempt to measure the extent of mental retardation within the country. This attempt followed fifty years after the first official U.S. Census and ten years after the first inclusion of any handicapping conditions (blindness and deafness) within the scope of the census. Although the U.S. marshalls responsible for data collection as part of the census of 1840 were charged with the task of acquiring data on the numbers of "insane and idiotic" within their census tracts, no attempt was made to distinguish between the two groups. What is more, no operational definition was ever presented to the marshalls to systematize the determination of which persons belonged to the class of insane and idiotic. In short, the determination of insanity or idiocy fell to the persons conducting the census, or to those heads of household who responded to their questioning. The respondents were asked simply whether any members of their household were "insane or idiotic at private charge" (at home) or "insane or idiotic at public charge" (in hospitals, almshouses, etc.). While the census of 1840 counted over 17,000 insane and idiotic, and based on comparable data for 1850 one might estimate that approximately 8,800 would have been idiots, the results of this census are most notable for the minor scandal they caused. In many instances, results of cross-tabulation between the total population within census tracts and the numbers of "insane and idiotic" within the same tracts were clearly impossible; in other instances, they were merely improbable. Greene County, Illinois, for example, was listed in the 1840 census as having no colored inhabitants. Nevertheless, the county was shown as having eight insane or idiotic colored residents. The newly founded American Statistical Association was quick to pick up on the more blatant problems within the Sixth Census, and on June, 1944, a group from the Association reported to the Select Committee on the Subject of Statistics of the House of Representatives. Their report in part said:

> In many towns, all of the colored population are stated to be insane [the category was, in fact, "insane or idiotic"]; in very many others, two-thirds, one-half, one-fourth, or one-tenth of this ill-starred race are reported to be thus afflicted; and, as if the document delighted to revel in variety of error, every proportion of the negro population, from seven-fold its whole number, as we have shown in some towns, to less than a two-thousandth, as is recorded of others, is declared to be lunatic.
>
> The errors of the census are as certain, if not as manifest, in regard to insanity among the whites as among the colored people .... The undersigned, in behalf of said association...believe it would have been better to have had no census at all, than such a one as has been published (House Reports, 1844, 8-9).

It was clear that some change would have to take place prior to the 1850 census, if its results were to be any more reliable than those of the previous one. For the most part, however, the concern shown in Congress was more directed to the apparent fraudulent abuses by the census takers than to the structure of the census itself. In the act authorizing the Eighth Census in 1850 it was specified that "each marshall, before entering upon his duties, [would be] required to take an oath or affirmation" (Wright & Hunt, 1900, p. 41). In addition, the responsibility for conducting the 1850 census was passed from the Secretary of State to the newly created Department of the Interior. There was, however, no response to the suggestion of the Select Committee on the Subject of Statistics that a Bureau of Statistics be created.

The changes which preceded the 1850 census had little effect on the types of data the census was directed toward gathering. Neither was the methodology substantially altered, although there was hope expressed that the fidelity of the census takers could be somewhat increased.

The 1850 census was the first one in which the "insane" and "idiotic" were treated as distinct categories. Additionally, it seems data were collected on the number of "idiots" in institutions. The Instructions to the Assistant Marshalls - 1850 Census (Wright & Hunt, 1900, p. 152) say:

> Should a poorhouse, asylum for the blind, insane or idiotic, or other charitable institution...be visited by the assistant marshall, he must number such building in its regular order, and he must write after the number...the nature of such institution...(and) opposite the name of each person he must state the character of the infirmity or misfortune.

Unfortunately, the data collected on idiotic persons in institutions, almshouses, hospitals for the insane and jails in 1850 were never reported.

Neither were they reported in 1860 or 1870, even though census takers were again instructed in those years to collect that information.

The census of 1850 enumerated 15,787 idiots, nearly the number of the combined category insane and idiotic of the 1840 census. The statistics collected showed large differences in prevalence among states and regions.

New Hampshire had the highest reported rate of idiocy in 1850 with about 110 reported cases per 100,000 population. Rates for all of New England averaged about 90 per 100,000. The rates for Southern states varied from Tennessee's 84 to Louisiana's 34 per 100,000. At the lowest extreme were the territories of Utah and California, which had reported rates of less than 10 per 100,000.

In addition, the Compendium of the Seventh Census provided a "Table of White Idiotic and Insane in Ten States in 1850." The rationale for this first inclusion of age data was that:

> It is of little importance...to know the mere number of blind and idiotic, if they are of extreme old age, and therefore, beyond the age of treatment. Upon the age of the person will depend the opportunity or hope of his amelioration (U.S. Census Office, 1854, p. 58).

The census of 1860 retained the format of the one which preceded it. Within its volume of Population, however, many pages were devoted to a sympathetic discussion of blindness, insanity and deafness. In addition, in his Introduction, Joseph Kennedy, the Superintendent of the Census, indicated what he considered to be the major barriers to collecting reliable information on the incidence of insanity and idiocy in the United States. Kennedy said:

> Of the obstacles which prevent a perfect return in regard to the various subjects comprehended in the Eighth Census, doubtless those which were encountered in the enumeration of the insane, and the idiotic, are greater and more nearly insurmountable than any others. Perhaps the greatest of them is that sensitiveness to public exposure which widely exists among persons who look upon mental alienation in a false light, regarding it as humiliating, and often a special dispensation of Divine Providence, rather than as one of the numerous diseases which afflict the human race, and from the liability to an attack of which no one can claim exemption. Persons cherishing these views not infrequently consider themselves justified in concealing a knowledge of the insanity (or idiocy) of a relative, when the acknowledgment of it to the census takers would, as they erroneously believe, lead to the publication of that relative's disorder, coupled with his name, in some official report (Kennedy, 1864).

In his introduction Kennedy also mentioned a census of idiots and insane conducted by the state of Massachusetts in 1854. In that census, physicians,

clergymen, "over-seers of the poor," "selectment" and superintendents of hospitals were asked to indicate those persons in their community who were insane or idiotic. In comparing the results of the Massachusetts returns from the 1860 census with those obtained in the special Massachusetts census of 1854, Kennedy concluded that the Massachusetts census was "undoubtedly more nearly perfect." It had enumerated 1,087 idiots in Massachusetts versus the 712 counted six years later in the national census. Kennedy went on to say, "It is hoped that, for the next national census, some method of enumerating these classes, which shall be equally efficient with that pursued in Massachusetts, may be devised" (Kennedy, 1864, p. 79). It would not be until the 1880 census that Kennedy's wish was fulfilled. But when it was, the result would be exactly what he expected, a large increase in the enumerated insane and idiotic.

The results of the 1860 census of the idiotic were nearly the same as those of the 1850 census. While the total number of idiotic persons identified rose by over 3,000 to 18,930, the rate per 100,000 dropped from 68.1 to 60.2. This drop was in part due to data included for the first time on three Midwestern states which were reported to have abnormally low rates of idiocy. But beyond this was the glaring fact that the reported rates within states between the 1850 and 1860 censuses showed high variability. For example, Delaware's reported number of idiots in 1860 was only 70% of the number reported in 1850. Its rate per 100,000 dropped from 100 to 60 during this same period. These differences cannot be accounted for by methodological changes, since the format for the 1850 and 1860 censuses was nearly identical. In retrospect, there seems little reason to accept Kennedy's judgment that the 1860 census was "a much nearer approximation to accuracy than either of those which preceded it" (Kennedy, 1864, p. 79). There simply does not exist any objective standard for comparison. The final report of the Eighth Census provided only tabular data regarding the idiotic, even though, as has been mentioned, long discussions are provided concerning other handicapping conditions. The only remarks which are devoted to the idiotic in the entire 1860 census are found in an 1862 Preliminary Report:

> IDIOTIC. The number of those unfortunate beings who constitute this class, while numerically greater, has decreased slightly in ratio to the population. As but little has been effected for the elevation of these imbeciles, and it is conceded that their condition

has rendered them, for the most part, incapable of mental improvement, the efforts of humanity have been mainly directed to their personal comfort and physical requirements.

> Among the numerous attributed causes of idiocy, none is more generally conceded by those who have investigated the subject, than the intermarriage of near relatives (U.S. Census Office, 1862, p. 57).

Prior to the initiation of the Ninth Census in 1870, a Committee on the Ninth Census was formed. On January 18, 1870, it presented its report to the House of Representatives. In that report, which provided a brief history of census taking in Western societies from the days of Athenian and Roman antiquity, the Committee proposed new legislation that would give permanence to the Office of the Census. Additionally, the proposed legislation would have allowed for more thorough data collection by providing heads of households with a copy of the schedule twenty days before the census taker arrived for the interview. Beyond these changes in the organization and instrumentation of the census, the Committee report called for new zeal in the gathering of information that a rapidly industrializing nation would need to make wise decisions. Even the recommendation that more detailed information be collected on persons with mental and physical defects contains this fervor:

> It is not generally known how large a proportion of each nation is wholly or partially unfitted by physical disability for self-support. The statistics of France show that in 1851, in a population of less than thirty-six million, the deaf, dumb, blind, deformed, idiotic, and those otherwise mutilated or disabled, amounted to almost two million. We thus see that in a country of the highest civilization the effective strength of its population is reduced one-eighteenth by physical defects. What general would venture to conduct a campaign without ascertaining the physical qualities of his soldiers as well as the number on his rolls? In this great industrial battle which this nation is now fighting, we ought to take every available means to ascertain the effective strength of the country (House Reports, 1870, p. 51).

Though this bill to expand the 1870 census passed in the House of Representatives, it was defeated in the Senate. As a result, the Ninth Census (1870) was conducted under the law which had governed the censuses of 1850 and 1860, and was similar in format to those earlier censuses.

Nevertheless, the census of 1870 was the first to make some attempt to aid the census taker in determining idiocy. A special section of instructions was offered for collecting information on certain classes of handicap. It said:

> Deaf and Dumb, Blind, Insane or Idiotic. Great care will be taken in the performance of this work of enumeration, so as at once

> to secure completeness and avoid giving offense....The fact [of] idiocy will better be determined by the common consent of the neighborhood, than by attempting to apply any scientific measure to the weakness of the mind or will (Wright & Hunt, 1900, p. 158).

In reality, however, it was only practical for the census takers to employ such a consensual definition at times when questions were raised in their minds since, for the most part, this enumeration of society's handicapped depended on a procedure whereby family heads were merely asked if any members of their family were deaf and dumb, blind, insane, idiotic, paupers, or convicts.

The census of 1870 counted 24,527 idiots, an increase of over 5,500 over a ten-year span. But the population of the country was increasing rapidly too, and in terms of rate per 100,000 on a national level, the results of this census were quite near those of the censuses of 1850 and 1860. There remained, however, within the states rather substantial flux in prevalence over the ten-year periods.

By 1870, there was apparently a growing conviction among those interested in the census of the handicapped that the procedures employed were not effective in obtaining an accurate count. Francis Walker, the Superintendent of the Census, commented on this in the Compendium of the Ninth Census (1872, p. 626):

> It is held by many persons conversant with the special subject, that the returns of the census in respect to the blind and deaf and dumb, and also, in a higher degree, to the insane or idiotic, are always, and necessarily, considerably below the fact. F. B. Sanborn, of Massachusetts, late Secretary of the Board of Charities for that Commonwealth, has advanced the opinion that the numbers reported in the census, be it State or National, rarely embrace more than sixty or seventy per cent of their respective classes.

In two years, Walker wrote of concrete evidence of the inaccuracies of his data:

> Since the following tables (of the 1870 census) were sent to press, the office has received, by favor of the Secretary of the Illinois State Board of Charities,[1] the lists, prepared for and by the Board of the Insane and the Idiotic in that State. The list of the idiotic has not been examined for the purposes of the remarks, but the list of the insane has been subjected to careful comparison with the returns of the census, name by name. This comparison exhibits such an utter want of correspondence, at nearly every point,

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[1] The Secretary of the Illinois State Board of Charities was Frederick H. Wines, who would be appointed Special Agent for the 1880 U.S. Census Report on the Defective and Delinquent Classes of the Population of the United States.

> as not only renders criticism impossible, but is, in itself, wholly inexplicable (U.S. Census Bureau, 1872, p. 426).

The list of insane provided by the Illinois State Board of Charities had 2,376 names. The 1870 census in Illinois had collected the names of 1,621 insane persons. When the lists were compared, it was discovered that only 721 names were common to both the lists.

In 1879, a bill was passed through both Houses of Congress providing important revisions in the methods previously employed in the census of the United States. For one thing, this bill established a Census Office in the Department of the Interior. Additionally, the bill responded to many of the problems evident in the censuses which had been conducted in the decennia prior to 1880. According to Wright and Hunt (1900, p. 59, 63):

> The entire inadequacy of the machinery provided by the law of 1850, under which the seventh, eighth and ninth census had been taken, had been made clearly apparent, especially at the ninth census period, and the work of supervising the enumeration, heretofore charged upon judicial marshalls, was by the new law intrusted to a body of officers specially chosen for the work....The collection of the social statistics...was also withdrawn from the general enumerators, under the provisions of Section 18 of the act of March 3, 1879, and the information was collected either wholly by experts and special agents without regard to locality, or partly by special agents and partly by correspondence.

The decision as to which classes of statistical inquiry would be taken from the hands of the ordinary enumerators and given over to special agents was left to the Census Office, and ultimately to its Superintendent, Francis Walker. Walker, who had commented at some length about the inaccuracies of the 1870 census in its count of handicapped persons, reported to the Secretary of the Interior in November, 1879, that eight special reports would be conducted. One of these was of "The Defective, Dependent, and Delinquent Classes." In the report to the Secretary of the Interior, Walker gave this rationale:

> The reason for the recognition of these classes, in preparing for a census, is fourfold: first, philanthropic, in order that humane efforts made by individuals or communities for the protection or relief, and, so far as possible, the restoration to society, of the unfortunate classes, may receive intelligent direction; secondly, scientific in order that the physiological laws which govern the appearance of mental and physical defects, and the social laws which govern the commission of crime, may be disclosed; thirdly, political, in order that the state may know what portion of its citizens are incapacitated for military and civil service; and fourthly, economical, in order that it may be known what is the burden laid by pauperism and crime upon productive labor, and what the extent to

> which exceptional physical infirmities and afflictions in classes of the population, as blindness, deaf-mutism, etc., create an exceptional liability to future pecuniary dependency (U.S. Census Office, 1883, p. 29).

In picking his special agent for this report Walker turned to the man who had so clearly demonstrated the inadequacies of the 1870 census of the insane and idiotic in Illinois, Frederick H. Wines. Walker wrote:

> Mr. Fred H. Wines, for ten years the Secretary of the Illinois Board of Commissioners of Public Charities, has been appointed the special agent of the Census Officer, and has undertaken an inquiry which for breadth of plan and fullness of detail leaves nothing to be desired.

Undoubtedly, the choice of Wines was heavily influenced by his having provided Walker, following the 1870 census, with more extensive lists of insane and idiotic persons in Illinois than had been compiled by the federal census takers, as was noted above. Beyond this, however, Wines was a man thoroughly familiar with the subject he was being charged with studying. Wines, during his thirty-year tenure on the Illinois Board of Public Charities, was involved in innovation in the area of treatment of abnormality, such as the establishment in 1877 of the first psychiatric treatment center in the United States built on the cottage plan.

Although a foresightful thinker and drafter of some of the more progressive legislation of his era (for example, the Illinois Lunacy Law), Wines' "Introductory Remarks" to the Report on the Defective, Dependent, and Delinquent Classes demonstrated concerns about these classes that were shared by many of his contemporaries. Said Wines (1886, p. 10):

> There is a morphology of evil which requires to be studied. How far it may extend, or what may be its ramifications, no one can yet say. All of these forms of misfortune are often a cause of pauperization of individuals and of entire families. Preventive work among children is calculated to check the growth of them all, or to alleviate the condition of their hapless victims. They strike those whom they assail at a very tender age, even before birth. And there is still another point of view from which they demand to be studied simultaneously and in connection with each other. This branch of the census may be likened to the wrong side of the balance sheet in making up the national account. We have enumerated our wealth of men, of money, of property of every description; we have ascertained approximately the rate at which we are advancing as a nation in all the material elements of progress. We need also to case a glance at the increasing burdens which civilization has to bear. A very considerable portion of the revenues raised by the several states by means of taxation is absorbed in the care of the criminal and the unfortunate; in some states, more than half of the general revenue fund is devoted

> to this specific end. For the information of legislatures, it is important that the whole extent of the evil to be contended against shall be known, and that it shall be accessible in a single report, in order that they may make adequate provision for its care or alleviation. The proper care of all these classes is the dictate alike of duty, of sentiment, and of self-interest. The subject demands a degree of interest and attention which it is difficult to secure for it.

There were, however, some contemporaries of Wines who objected to categorizing those on "the wrong side of the balance sheet" of the nation's human resources as defectives. Wines acknowledged these objections in his Introductory Remarks, responding that:

> The insane, the idiots, the blind and the deaf are known in the census by the title defectives, or the defective class. Exception has been taken to this word as offensive, and not really descriptive in its application to them. The force of this exception is freely admitted. I should have preferred another term, had I been able to think of a better, but no one has suggested a better. The deaf and blind lack the sense of hearing or the sense of sight; the idiots lack the full development of their mental powers; and the insane have lost, to a greater or less extent, the faculty of reason or the balance between the intellectual powers of which, before becoming insane, they are possessed, and which the most of them still partially retain. In the case of these four classes, their claim to the protecting care of the government is, therefore, based on a physical or mental defect ....It is because of this peculiar relation which they sustain to the public, that they are enumerated in the census, in order that the governments referred to may know the precise extent of the claim which may justly be made in their behalf and the amount of provision to be made for them (Wines, 1888, p. 8).

For Wines, the need to thoroughly carry out the census of society's deviants was urgent. He could be content that many of these misfits he set out to enumerate were victims of fate, but that did not negate their place in the "morphology of evil" that demanded study. Wines set out to weigh society's burden, and to Wines, these various nonconforming elements were not unique and unrelated, merely be summed to obtain the total cost to society. On the contrary, they were highly related, influencing each other in some unknown, almost sinister way. About studying the different elements of the nonconforming classes in one study, Wines said:

> To my mind, the entire subject is one. The causes that work in modern society, with its high degree of organization and development, which tend to hasten the growth of either of the forms of misfortune included in this inquiry, affect the growth of all of them. The physical and moral causes which are the occasion of insanity in one man excite another to crime. The connection between crime and pauperism

> is exceedingly close; so is the connection between crime and imbecility; but not more intimate than that between insanity and idiocy....It is a well-ascertained fact that, in the operation of that mysterious but potent factor in the production of defective types of humanity which we call heredity, insanity in an ancestor may become idiocy or crime in a descendant, and vice versa (Wines, 1888, p. 10).

With this sense of urgency in locating and enumerating the deviant classes, it is not surprising that Wines and his co-workers developed procedures far more extensive than those employed in any previous census. Wines' procedure for the enumeration of idiots and insane persons had three phases. It began with:

> ...a list of institutions, throughout the United States, prepared with great care in advance of the actual taking of the census, so that it is demonstrable that few, if any, of the important charitable and correctional institutions of the country failed to be accurately reported. Second, a system of special schedules was devised, one for each separate class; and every enumerator was required not merely to enter upon the general population schedule the name of every defective person enumerated by him, but also to transfer the name of every such person to its appropriate special schedule and upon the schedule to answer certain definite questions, applicable to him as a member of the class to which he was supposed to belong. For this extra service, the enumerator was offered additional compensation; and it was impressed upon him that he should exert himself to find these defective persons, and to make a full report of each case. He was asked to counsel with physicians upon this point, to make inquiries of neighbors, and to report all defectives, whether the information respecting them should be derived from the family to which they belonged or from other sources, if in his judgement it was worthy of confidence. By this method it was sought to obtain approximately as complete an enumeration of defectives outside of institutions as of the inmates of such institutions. Third, with respect to the idiots and insane, the work of the enumerators was supplemented by correspondence with physicians, in all parts of the United States, to the number of nearly 100,000, all of whom were furnished blank forms to return, and were invited and urged to report to the Census Office all idiots and lunatics within the sphere of their personal knowledge. Four-fifths of them responded to this invitation.... (Wines, 1888, p. 10).

The third step in Wines' methodology of enumeration, that of asking physicians to furnish reports of idiots and lunatics known to them, may have been the result of the successful use of that procedure in a special census of insane and idiotic by the state of Massachusetts in 1854. But Wines and his co-workers were not simply after the numbers of persons falling within the "defective classes," although they were successful in enumerating over three times the idiots that had been counted just ten years prior. It was Wines' hope that the members of the defective, dependent and delinquent classes could

be studied in more depth than had ever been done before on such a large scale. To this end, the supplemental schedules were developed. (The 1880 supplemental schedule for idiots can be found at Appendix A with a list of the specific questions contained within it.)

In all, the 1880 census of idiots enumerated 76,249 members of that class. In addition, detailed information was collected on 27,661 idiots. This data included the ability of those studied to use hands, feet and speech as well as the individual's head size. From this information Wines outlines a methodology for the classification of the severity of the idiocy. Said Wines of his sample:

> These may be divided into five general groups: those which, in respect of the head size, use of hands, use of feet, and the power of speech are in the highest grade; those in the highest grade of any three of these particulars; those in the highest grade in respect of two; those in the highest grade in respect of one; and those not in the highest grade in any particular. [Unfortunately, Wines did not specify how one's being in the highest grade of power of speech, for example, was defined or measured.] The first of these groups numbers 427; the second, 4,406; the third, 8,558; the fourth, 9,422; the fifth, 4,848 (Wines, 1888, p. 44).

Wines went on to discuss the results of this rather detailed study of over 27,000 idiots saying:

> The first group, which contains those who have heads of natural size, who can speak well, and do skilled labor, are not, if correctly reported, idiots....
>
> The idiocy of those in the second group may be questioned. Of this group, 194 are equal to those of the first group in every particular, except that their heads are not believed to be of natural size....
>
> The third group is inferior to the other two. It contains, however, 231 persons capable of skilled labor....
>
> In the fourth group, we find a large number (1,140) of those who can neither walk nor speak...but, even in this group, 3,934 can do coarse labor, and 35 are reported to be capable of labor of a higher grade....
>
> The lowest grade contains 1,173 who cannot walk, 2,368 who cannot speak, and 1,304 who can do neither. Even in this group, however, there are 833 who can do coarse manual labor (Wines, 1888, p. 45).

Having looked at the results of this more close examination of over a third of the idiots whom his census managed to enumerate, Wines was compelled to recognize that over one-sixth of this group may not have been idiotic by what seemed to him a reasonable definition of the affliction. There seemed only one obvious conclusion and Wines drew it. He said:

> I think its quite apparent, without further examination... that idiocy is largely a question of definition, and that it is scarcely possible to form a correct opinion as to the amount of it from the enumeration contained in the census (1888, p. 45).

Owing to Wines' procedures of enumeration, the census of 1880 counted over three times the number of idiots than had been counted just ten years prior. Twenty-nine percent of this total came from the schedules supplied directly to physicians (U.S. Census Bureau, 1895). In addition, the 1880 census provided the first nationwide data on the number of mentally retarded persons in public institutions. Table 1 shows the results of the censuses from 1850 - 1880 in terms of the reported prevalence and incidence of idiocy. Table 2 summarizes the place of residence of those persons identified as idiots in the 1880 census.

Wines observed on the basis of the 1880 data that of all the handicapped groups, those whom we now call mentally retarded are the least provided for. He commented:

> Provision for the training of idiotic children is of comparatively recent origin and has not yet reached its full development. There are not one-half so many schools for the feeble-minded as there are for the blind, yet they contain a considerably larger number of inmates, which goes to show that there is a great unsatisfied demand in the direction, and that the movement for the relief of idiots is in its infancy (U.S. Census Bureau, 1888, p. 28).

To Wines, providing for the idiotic meant training in institutions for that class. At one point, he indicated that:

> Of the 74,466 idiots outside of institutions [specifically for idiots], so far as it appears to us, only 809 have received any special training [spent time as an inmate in an institution, and following the training had been released]; and this not withstanding the fact that idiocy, as we have seen is a disease of infancy, three-fourths of the entire number being congenital cases (1888, p. 37).

After locating in his census 809 idiots who had formerly been inmates of institutions for that class Wines commented that:

> These are certain and positive fruits of the system of public charities in this country. But there is reason to believe that the actual result, could it be ascertained, is very much greater than these figures would indicate (1888, p. 37).

Since the 1880 census was the first to include in its final report the number of idiots in institutions, there is little in the way of comparison that can be done with Wines' findings. It is clear, however, that this census took place during a period of considerable growth both in the numbers and size of

Table 1

Idiotic Persons Identified by the U.S. Census
over a Thirty-year Span

Census Year	1850	1860	1870	1880
Number	15,787	18,930	24,527	76,895
N/100,000	68.1	60.2	63.6	153.3

Table 2

Residency of Idiotic Persons
Enumerated by the 1880 Census

Total	Institutions for Idiots	Institutions for the Insane	Other Institutions	Almshouses	Prisons/ Reform
76,895	2,429	1,141	241	5,867	47

institutions for the retarded. In his special enumeration, Wines mentioned the four largest institutions for the mentally retarded in the United States in 1880 and furnished their inmate populations. Then Wines' figures are compared with those provided in the Proceedings of the Annual Session of Medical Officers of American Institutions for the Idiotic and Feeble-minded, 1879, a very sizable growth in these four largest institutions can be seen to have taken place between 1878 and 1880. Table 3, found on page 22, shows that growth.

A comparison of the 1878 and 1880 figures shows an increase in the inmate population of the nation's four largest institutions of 35% over a two-year period. Whether all of the nation's other six institutions were experiencing equally rapid growth rates during this period is not known for sure, but it is clear that at least one of them was growing rapidly. At the 1879 Annual Session of the Medical Officers, O. W. Archibald of Iowa reported:

> On September 5, 1876, we organized our school with only two children, but gradually received new recruits, until, at the end of fourteen months, we had in our school eighty-five pupils.
>
> At the present time, just two years and a half from our opening, we have one hundred and thirty-six children, with fourteen others accepted, making our school number one hundred and fifty, which is the utmost capacity of our building, and already have rejected sixty-five urgent applications for want of room (Status, 1879, p. 106).

Before the mountains of data collected in the 1880 special report could be tabulated by the clerks hired for that purpose, edited into a volume and published, the year was 1888. By then the ten states with institutions about which Wines reported had been joined by four more. Between the 1887 and 1888 Annual Sessions of the Medical Officers, in the words of the organization's president, George Knight, "two more states [had] fallen in line" (Knight, 1888, p. 51). This was a period of very rapid growth in providing for institutional care for retarded persons. Knight summed up this period of institutional growth in 1888 when he reported to his colleagues, the administrators of these institutions, that "public sentiment is with us" (1888, p. 51).

It was during this period of rapid expansion of institutional facilities for the mentally retarded, and only two years after the publication of Wines' 1880 census, that the 1890 <u>Report on the Insane, Feeble-minded, Deaf and Dumb and Blind in the United States</u> was carried out. As the title of the special census indicates, it was concerned only with the class of persons considered defectives in Wines' study of "defective, dependent and delinquent classes."

In other words, paupers and convicts were not included in this special census.

This study, under the direction of Dr. John Billings, who at the time of his appointment as Expert Special Agent was Deputy Surgeon General of the Army, was more restricted than the 1880 census in other ways. The major difference in the methodology of gathering demographic information on the "feeble-minded" (the term used in the Billings' special census, and equivalent to Wines' "idiots"), did suggest to the enumerators that "valuable hints as to the existence of feeble-minded and idiotic persons in the neighborhood and their residence may be obtained from physicians in their respective districts" (Wright & Hunt, 1900, p. 206). Inasmuch as prevalence figures in the two censuses are nearly the same, it would seem that enumerators must have availed themselves of this or some similar technique to locate those feeble-minded persons who had eluded census takers prior to 1880. It was to their advantage to do so since reimbursement for the enumeration of defectives was more than twice the rate paid for the normal populace.

Another difference between the two special censuses was the absence in the latter of the extensive analytical narrative which accompanied the tables of the 1880 census. Whereas Wines had gone to great lengths to describe his findings and draw conclusions from them, Billings limited his presentation of the data primarily to tables. Where Wines had pointed out how idiocy rates decreased consistently as one moved west and south from New England, Billings apparently had found it sufficient to provide the rates for the various states and leave the analysis to the reader. Despite these differences, the special census of 1890 was modeled after that of 1880 and, therefore, allows many parts of the two to be compared. One area in which the two are comparable is in the report of institutionalized feeble-minded persons.

In the span of ten years, from 1880 to 1890, the number of public institutions for the feeble-minded had doubled from ten to twenty. Additionally, there were four private institutions reported in 1890, where none had been found in the 1880 census. There were now 5,254 persons listed as being patients in institutions for the feeble-minded versus 2,429 just ten years before. The numbers of feeble-minded in institutions for the insane also doubled during this period, going from 1,141 in 1880 to 2,469 in 1890. Yet, because of the change in scope of the 1890 census, no data were reported on the number of feeble-minded in other types of institutions and prisons. It

is known, however, based on the data compiled for the 1890 Census Report on Paupers, that 7,811 inmates of almshouses were listed as idiots (U.S. Census Bureau, 1895). This compared with 5,867 in 1880.

The 1880 and 1890 censuses also seem worthy of comparison in terms of the total number of idiotic feeble-minded persons counted. In that ten-year period, the number of enumerated feeble-minded persons rose from 76,249 to 95,571. But the nation's population was rising very rapidly as well. In terms of feeble-minded persons per 100,000 population, the 1890 data provided a rate of 152.7 as compared with 153.3 in 1880 for the U.S. as a whole. Comparisons within and between states showed extreme fluctuations between the two enumerations. The rate of Rhode Island, for example, went from 84.6 per 100,000 in 1880 to 141.2 in 1890. (An intermediate state census in Rhode Island in 1885 had shown the rate to be 71.6.)

Billings, like Wines in the 1880 census, also discovered that the Western and Southern states had substantially lower rates of feeble-mindedness. Both censuses found that the prevalence of feeble-mindedness in cities of over 50,000 was less than half the national average. Again, however, those rates were highly unstable between censuses, with Washington, D.C.'s rate going from 52.3 to 113.3 in ten years, while the rate in Buffalo dropped from 90.2 to 59.5 during the same period. The largest shifts in rates during that period among cities over 50,000 were reported for Columbus, Ohio and Syracuse, New York. In these cases, however, it is clear that the rapid growth of the large institutions located in these cities during the ten-year period accounted for most of that change.

As can be seen in comparing the supplemental schedules in Appendix A, the format of enumerators' interviews was quite similar in the 1880 and 1890 censuses. There was, however, one significant addition to the 1890 schedule. This regarded "whether [the feeble-minded person] has had, or now has, any insane or feeble-minded relatives" (Wright & Hunt, 1900, p. 205). Billings obtained this information on 44,033 of the 95,571 feeble-minded persons enumerated. The rate of feeble-minded persons with feeble-minded relatives reported by Billings was 56.4 percent. Going back over Wines' data for 1880, Billings located 8,728 persons on whom information about relatives had been recorded. (Wines did not include this data in his report.) Using this information, Billings found that the rate in the 1880 group was 51.3 percent. We are

provided no way of knowing how this sub-population which was examined for other cases of feeble-mindedness in the family was selected. There appears no reason to assume this selection was in any way random.

Almost as suddenly as these enormous undertakings of enumerating the nation's defectives were given high priority among the many possible special investigations of the Census Office, they were halted. The 1900 special censuses were devoted primarily to the nation's interest in its rapidly growing industrial and commercial spheres. No inquiries about any special classes were authorized as special reports in 1900, and none were included with the general census of the population.

Table 4 contains highlights of the census data from 1850 - 1890 concerning the numbers of enumerated mentally retarded persons in the United States and also the numbers of mentally retarded persons found in institutions for the feeble-minded and insane in 1880 and 1890.

From 1899 through 1902 a good deal of attention was devoted in congressional committees and floor debates over the creation and organization of a permanent Bureau of the Census. Many scientists, economists and statisticians were asked to testify and most did so in favor of a permanent Bureau. After a good deal of debate and several amendments, a bill was passed through both Houses of Congress and was signed by the President on March 6, 1902. This legislation created a permanent Bureau of the Census within the Department of the Interior. (The Bureau was transferred to the Department of Commerce and Labor the following year.) W. R. Merriam was made the first full-time Director of the Census and Frederick Wines was appointed Assistant Director.

The debates which had preceded the passage of this legislation had focused not only on the potential statistical improvements which would come from a permanent Bureau, but also on ways to economize and streamline the agency. After all, argued a number of persons, much of the information collected by the census was outdated before it could be disseminated. For this reason, a number of restrictions were placed on the work of the Bureau. One of these greatly restricted future enumerations of special classes.

According to the legislation,

> The Director of the Census [was] authorized to collect statistics relating to special classes; including the insane, feeble-minded, deaf, dumb, and blind...Provided [emphasis within legislation], that the reports herein authorized relating to mines, mining, and minerals shall be published on

Table 3

Growth of Inmate Population of the Four Largest Institutions for Idiots, 1878-1880

Location of Institute	1878	1880
Columbus, OH	400	549
Media, PA	260	322
Lincoln, IL	160	306
Syracuse, NY	270	295
	1,090	1,472

Table 4

Idiotic Persons Enumerated by U.S. Census, 1850-1890

Census Year	1850	1860	1870	1880	1890
Number	15,787	18,930	24,527	76,249	95,571
N/100,000 Population	68.1	60.2	63.6	153.3	152.7
# in Institutions for Mentally Retarded	--	--	--	2,429	5,254
# in Institutions for Mentally Ill	--	--	--	1,141	2.469
# in Almshouses	--	--	--	5,867	7,811

> or before July first, anno Domini nineteen hundred and three (House Report, 1902, p. 48).

Even, however, should the Bureau be able to conclude its census of the mining industry on time, other restrictions were included in the legislation:

> The statistics of special classes, and of crime, pauperism and benevolence specified in this section shall be restricted to institutions containing such classes [emphasis provided]....The collection of statistics authorized by this section shall be made at such time or times and in such a manner as will not interfere with nor delay the rapid completion of the census reports provided in section seven of this act [population, mortality, products of agriculture and manufacturing], and all reports prepared under the provisions of this section shall be designated as "Special Reports of the Census Office" (Ibid., p. 49).

The first "Special Report" conducted under the new law was of "Insane and Feeble-minded in Hospitals and Institutions." The study was undertaken in 1904 and published in 1906. As required by the Act of March 6, 1902, it was limited to institutionalized persons in facilities for the insane and feeble-minded.

Summary

Decennial enumerations of idiots and the feeble-minded were conducted between 1850 and 1890. In each census, an attempt was made to count all idiots or all feeble-minded persons within the nation. These enumerations were part of the regular census until 1880. In that year, the work of the regular census takers were supplemented with lists provided by approximately 100,000 physicians who were asked to provide the names of the idiots of whom they were aware. These special lists accounted for 29 percent of the total enumeration. In addition, the 1880 census takers were provided with supplemental schedules on which they gathered additional information on "defectives." Also reported for the first time in this census was the number of institutionalized persons.

While the 1890 census did not appear to approach its enumeration of special classes with the same rigor as the census which preceded it, the results of the census were remarkably similar to the 1880 census. In 1880, 76,895 persons were found to be idiots; in 1890, 95,609 feeble-minded were counted. Still, the number per 100,000 population in the two years was 154.3 and 152.7, respectively. Between the two censuses, the number of feeble-minded persons institutionalized doubled.

In 1900, no census of special classes was conducted. In 1902, the act of Congress governing the work of the Bureau of the Census prohibited the Bureau from attempting any other general census of special classes. From 1902 on, studies of feeble-minded persons were limited to those who were inmates in institutions.

ENUMERATIONS OF FEEBLE-MINDED PERSONS IN INSTITUTIONS IN CONJUNCTION WITH THE DECENNIAL CENSUS, 1900-1923

An extensive study of the mining industry and the mineral wealth of the United States was completed on schedule and published with the rest of the Twelfth Census of 1900. As authorized, the Bureau then began planning for a census of institutionalized special classes.

John Koren, a statistician and permanent employee of the Bureau of the Census, was appointed Expert Special Agent for the "Special Report on Insane and Feeble-minded in Hospitals and Institutions: 1904." Not only was Koren's area of inquiry limited by the 1902 legislation, it was also limited by his concept of the role of the statistician. Said Koren (U.S. Census Bureau, 1906, p. 205) about the rigid demographic orientation of the special census:

> It is not feasible to enter upon a more intimate statistical study of a small group of this class at the present time. In fact, what belongs to the etiology of feeble-mindedness should be elucidated by medical experts rather than by statisticians, and so long as alienists make but little progress in diagnosis of the origin of feeble-mindedness in the individuals under their personal observation...it is extremely dangerous for statisticians to enter upon the field.

Because of this feeling on Koren's part, which may well have been influenced by the reality that he was legally authorized to do little more, the 1904 special report did not deal "with the causes and kinds of feeble-mindedness, the family relations of the defective, nor any other aspect of the etiology of the individual case" (Ibid).

Still, while apparently satisfied with conducting a study which avoided the genetic and medical questions related to feeble-mindedness, Koren was clearly disturbed by the restriction to institutions of the census of special classes. In Koren's opinion (Ibid, p. 206):

> ...what should be the primary object of an enumeration of the feeble-minded [is] to determine the number and distribution of all the feeble-minded in the country. The importance of accomplishing this one object can not be overestimated. The existing provisions

> made for the institutional care of the feeble-minded are, on the whole, much less adequate than those of other defective classes, and in many sections of the country they are wholly lacking. Little improvement, however, can be looked for as it is not even known how many stand in need of such care.

Koren's estimation was that the number of feeble-minded outside of institutions who "urgently require(d) institutional care" was in the "thousands." Still, that was another study to be put off until Congress could comprehend its importance. For now Koren's job was "merely to give in outline, a statistical picture of the movement of population in special public and private institutions or schools for the feeble-minded during twelve months, together with general facts in regard to the color, sex, age, and nationality of the inmates (p. 206). Copies of the Schedules used are attached in Appendix A.

The period between the 1890 "Report on the Insane, Feeble-minded, Deaf and Dumb, and Blind" and the 1903 study was one of significant growth in all types of charitable institutions. During this period the greatest increase occurred among those institutions designated as for the insane, where the number doubled from 162 to 328. Substantial growth occurred as well among institutions for the feeble-minded. These institutions grew from a total of 24 in 1890 to 42 in 1903. During this period private institutions for the feeble-minded increased by ten, while public institutions increased by eight. By 1903 there were 21 states which had a private, but no public, institution. During this thirteen-year period, nine states which previously had not had either public or private institutions, made provision for the institutional care of the feeble-minded.

As large as was this growth in the number of institutions, even greater was the growth in the size of the public institutions. The reason for this may have been accurately assessed by Enerich (1917) when he said that "it seems easier to get the legislature to appropriate funds for more buildings for the institutions we already have, than it does to get new institutions" (p. 74).

Institutions for the feeble-minded faced two great pressures during this period. The first was the pressure to admit more and more children. The sentiment of the nation seemed to support Wilmarth's (1895) "fullest faith that there [would] be no halt in the progress...until this class, largely created by the sins of ancestry and the senseless laxity of laws regulating marriage, has protection from the vicious element of society and the indulgence of their own natural instincts, unbridled by the control of a moral sense" (p. 517). But the other pressure was to do all this at the least possible cost. The concern

over minimizing costs of institutional care permeated the discussions of the Medical Officers of these institutions. Many practical suggestions on how to keep down costs were offered, such as the one by Dr. A. C. Rogers of the Minnesota School for Feeble-minded at Faribault, who reported: "Low grade children who can do nothing else are set to carrying stones from one pile to another, and by these well-directed efforts, the destruction of clothing and furniture is prevented" (1895, p. 593). But while this sort of effort could save the public substantial amounts of money, it was in making the institution as self-sufficient as possible that the savings could be maximized. It was the large institution with its many departments that could bring about the largest savings, and so the institutions grew.

During the period from June 1, 1890 until December 31, 1903, the population of institutions for the mentally retarded grew from 5,254 to 14,347. In the calendar year 1904, that number grew another 1,164 to a total of 15,511, showing nearly a three-fold increase in a period of fifteen years. Of these totals, only about 3.2 percent were residents of one of the fourteen private institutions.

By 1904 the average public institution held over 500 inmates, doubling the average resident population of only fourteen years before. The largest institution, The Asylum for Feeble-minded Children in Lincoln, Illinois had grown to a population of 1,241, more than four times as large as it was a quarter century earlier.

In addition to directing the study of the insane and feeble-minded in hospitals and institutions, Koren was concurrently in charge of the 1904 report on "Paupers in Almshouses." While finding that the number of almshouses had only grown from 2,373 to 2,476 since 1890 and that the rate of "paupers cared for by the public authorities in almshouses" had dropped from 132 to 101 per 100,000 of the general population, Koren noted that the number of feeble-minded in almshouses had grown from 7,811 in 1890 to 16,551 in 1904. Twenty percent of all those in almshouses were reported to be feeble-minded. But Koren warned, "the classification of paupers as insane, feeble-minded, etc., lays no claim to scientific precision; therefore, some of the persons designated as insane are probably only feeble-minded and vice-versa" (Bureau of the Census, 1906, p. 35).

For the first time in the 1904 study, patient movement was observed. During that year, 2,599 persons were admitted to institutions, while 574 died, 212 were

transferred to other institutions, and 635 were discharged. Of those discharged, 571, about 88%, were placed in the custody of relatives or friends, while 9% were released outright.

Concerning the condition of the inmates of the institutions for the feeble-minded, Koren noted:

> More than three-tenths, or 30.2 percent, of the feeble-minded in institutions were defective in other ways. Among this class epilepsy seems to have been the most common additional defect, as nearly three-fifths of them were epileptics. The maimed, crippled, or deformed were slightly more numerous than the paralytics, who constituted nearly one-sixth of those with additional defects. The proportions of deaf-mutes (1.5%) and blind (.2%) among the class were small.

As the first thorough study of the characteristics of inmates of institutions for the feeble-minded, Koren's special report forms a comparative base for demographic studies of institutionalized populations in the years that follow. But this study and all subsequent governmental studies lacked the vigor of earlier census studies. The studies became, henceforth, straight statistical descriptions of institutional populations.

At the time of the Thirteenth Census in 1910, another study of the Insane and Feeble-minded in Hospitals and Institutions was undertaken. Like the special report of 1904, this census did not require special enumerators. The procedure for these special enumerations involved the following system, described by Joseph Hill, the Expert Special Agent for the 1910 study:

> The canvas was made through the agency of officials or other persons connected with the institutions who were commissioned as special agents of the Bureau of the Census to fill out and return the required schedules. A sheet schedule with a line for each name was used for the enumeration of inmates at the beginning of the year; but the records of admissions during the year were obtained on individual cards which were filled out and returned to the Bureau each month. Similar card schedules were obtained for inmates who were discharged or were transferred to other institutions, or who died (Bureau of the Census, 1914a, p. 11).

Like his predecessor, Hill undertook his restricted task (enumerating only those feeble-minded who were in institutions) with a feeling that an important task was being overlooked. In his final report, he discusses a census conducted in Massachusetts in 1912:

> An indication of the situation as to the feeble-minded in a single state is furnished by the Massachusetts state board of insanity, which has charge of institutions for this class. According

> to the report of this board for 1912, the results of a special census of the feeble-minded showed a total of 5,007 feeble-minded enumerated in the general population (2,640 males and 2,367 females). In addition, 245 were reported by the overseers of the poor, making 5,252 not in institutions. The number in institutions was 2,587, including 1,915 in two state institutions for the feeble-minded and 672 in state hospitals and asylums. According to this census, the total number of feeble-minded in the state was therefore 7,839. The Census was not regarded as being complete, but is of interest to note that if the number of feeble-minded in proportion to total population was the same for the entire United States as it was in Massachusetts according to this census, the total number of feeble-minded would be over 200,000. Probably this may be regarded as a conservative estimate of the number of feeble-minded in the United States. It would indicate that not over one-tenth of the feeble-minded are being cared for in special institutions (Bureau of the Census, 1914a, p. 183-184).

The 1910 special report revealed that the number of institutions for the feeble-minded had grown rapidly in just six years. From the 1904 total of 42 institutions, 28 public and 14 private, the numbers had swelled by 1910 to 63, 35 public and 28 private. As the number of institutions grew, so too did their populations. By January 1, 1910, the numbers of persons in special institutions for the feeble-minded was reported as 20,731.[2] Of these persons, 19,499 (94%) were residents of public institutions and 1,232 (6%) were residents of private institutions.

In 1910 a special report on "Paupers in Almshouses," was conducted by Hill and ran concurrent to the census of insane and feeble-minded. In that report 13,238 feeble-minded persons were reported among institutionalized paupers. While Hill commented that "it should be noted that the number of insane, feeble-minded, and epileptics in almshouses is doubtless an understatement" (Bureau of the Census, 1914b, p. 42), his analysis of patient movement during that year revealed that almshouses were being less frequently used for housing the feeble-minded. On January 1, 1910, 15.7 percent of all persons in almshouses were listed as feeble-minded. This compared with 20.2 percent in 1904. Of those admitted to almshouses in 1910, only 4,408 were feeble-minded. This compared with

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[2]The survey form was not returned by South Dakota in 1910. Interpolation form 1904 and 1916 data from South Dakota would indicate about 180 residents in that state's institution. Using that figure, rather than zero as used by Hill, the total inmate population of institutions for the feeble-minded in 1910 would be 20,911.

6,363 feeble-minded admitted to almshouses in 1904. In other words, by 1910 only five percent of those admitted to almshouses were feeble-minded versus about eight percent six years before. The reason for this change did not elude Hill. In his introductory remarks to the special report on "Paupers in Almshouses" he says: "The number of insane and feeble-minded in almshouses is shown to be declining, doubtless as a result of the establishment of special institutions for the care of these classes of defectives" (Bureau of the Census, 1914b, p. 10). The data from the 1904 special report show the ratio of feeble-minded in almshouses to feeble-minded in special institutions to be 115.4/100. By 1910 that ratio dropped to 63.9/100. The "special institution" was by 1910 clearly accepted as the most appropriate place to send the feeble-minded. Unfortunately, as was the case in 1904, the 1910 report provided no information on the number of feeble-minded who were inmates in hospitals for the insane.

While there appears to have been considerable movement of patients from almshouses to special institutions from 1904 to 1910, there was no substantial shift in the age distribution of the inmates of these institutions. In both years, the percent of residents under the age of thirty remained about 86 percent. Admissions figures for 1910 show that about 74.2 percent of new patients fell in the 0-19 age range, with about 50 percent of the new admissions falling from 10 to 19 years of age.

In the one-year period of January 1 to December 31, 1910, 3,825 persons were admitted to institutions for the feeble-minded (3,531 public and 294 private), 1,009 inmates were discharged from these institutions, 180 were transferred to other types of institutions, and 895 died. Of those inmates discharged, only 55 were reported as able to care for themselves.

It is of interest to note that while on a national level there appeared certain degrees of stability in demographic characteristics of people institutionalized as feeble-minded, there was considerable change in the physical characteristics reported for those residents. Based on figures from the 1904 and 1910 enumerations, the percentage of physically defective declined from 30.2 to 25.3 during that period. The explanation for this decline may be in the growth in the numbers and size of institutions for the feeble-minded which could now admit less severely handicapped persons than they could previously. In 1910 the percentage of physically defective admissions had dropped to 23.8.

Equally interesting in looking at physical characteristics of the institutionalized feeble-minded persons are the differences in percentages of physically defective among institution populations in the various regions of the United States. In the most urbanized and developed New England and Middle Atlantic states the physically defective made up from 15 - 20 percent of the total institutionalized population, while in the much more sparsely populated states west of the Mississippi River, the percentages of physically defective ran more than two times the rate of the Eastern states. This differential may be explained in part by the greater difficulty in dealing with a physically handicapped person in the more rural parts of the country, but equally important is that most of the Western states had rates of institutionalization considerably below those of more urban states. In other words, these Western states seemed to be not yet at the point of active recruitment of institutional populations. These states were not long to remain behind, however. During the 1910 calendar year, the residential population of institutions for the feeble-minded in the Mountain and Pacific states grew fifty percent.

In his discussion of the results of the census, Hill commented on the growth of institutions and noted how he felt their function was perceived by his contemporaries:

> Institutional care of the feeble-minded...has become almost entirely a function of the state. A variety of causes have combined to produce this result. The tendency of the day is to regard all dependents of whatever class as wards of the state, for whose care the state is primarily responsible. Another influence may be the realization that the state institutions are to a considerable degree superseding the almshouses and like them are discharging a public function in caring for the defective class. Still another, and probably the most important cause, is the increasing conviction that the segregation and institutional care of the feeble-minded is necessary, even more as a matter of protection to the public than of benevolence for the inmates, and that the needed care can be secured only through the enforcement of law, which can scarcely be intrusted to private institutions (Bureau of the Census, 1910a, p. 184).

It is interesting to compare Hill's observations with those of William Harris in a Summary of State Laws Relating to the Dependent Classes: 1913 (published in 1914). In the summary Harris took note of the "change in the attitude of the state and the public toward those who are unable to provide for themselves, whatever the cause of their inability" (p. 5). Harris cited what he considered evidence of this change contained within laws providing for

dependent classes:

> Insane asylums are called state hospitals; state "charity" with its almost inevitable stigma, is gradually giving place to state "aid," and it is coming to be recognized that the mere fact of inability to support oneself does not necessarily involve any disgrace. That stage, indeed, has not been reached everywhere, but that the later laws in many states have been framed in recognition of it is very evident (p. 5-6).

Harris continued, saying:

> This change in attitude has been accompanied by a marked tendency toward the centralization under state auspices of those agencies for the care and relief of dependents, which formerly were left distinctively to local authorities -- town, county, or municipality; and state after state has made statutory provision for that care and for its supervision or control (p. 6).

Harris went on to point out that in 1904 only 15 states had any organization to supervise the functioning of charitable and correctional facilities within its boundaries. But within "another decade...there is not a single state that does not, in some form, recognize its duty to secure better care for those who cannot care for themselves" (p. 6).

Harris characterized the contemporary legislation as follows:

> Thus the laws affecting dependent, neglected, and delinquent children almost invariably contain the caution and the injunction that they should be interpreted liberally, to the intent that the child's best interests may be subserved; and with this in view the child...is to be placed in a good home or a well-conducted institution, or, better still, kept in its own home, even if it costs the state something to keep it there....The feeble-minded...and others are no longer regarded as drags upon the community, who must somehow be taken care of, but as unfortunates to whom the community owes relief and support (Bureau of the Census, 1914c, p. 6).

The contrast between the observations of Hill and Harris in the two Census Bureau documents, both published in 1914, is rather remarkable. Clearly this period stood out as one in which no single attitude could be attributed to the populous as a whole. A number of reasons for this lack of consensus can be mentioned. For one thing, it appears that many people in the community did not find the idea of locking a person up because he was considered feeble-minded easily justifiable. This was especially true with the "moron class," the "mildly retarded" persons who had struck so much fear into the hearts of those who had considered all social problems from crime, to pauperism, to insanity, to feeble-mindedness, interrelated and inseparable thirty years prior. Said

Fernald (1919, p. 119):

> That such misgivings are well-founded is apparently shown by the studies made of discharged patients at Rome and Waverly. At Waverly, a careful study of discharges for twenty-five years showed that a very small proportion of the discharged male morons had committed crimes, or had married or become parents, or had failed to support themselves, or had become bad citizens.

As time appeared to strip away the fear that had directed the public attitude toward the feeble-minded, what was left? The answer seemed to be: the cost. Fernald spoke to this as well, saying:

> The average citizen is not yet convinced that he should be taxed to permanently support an individual who is capable of thirty, fifty or seventy percent of normal economic efficiency, on the mere theory that he is more likely than a normal person to become a social problem (1919, p. 120).

What was the cost? No one, it seemed, had ever asked that question. By 1915 there were over 500 institutions, hospitals, colonies and other facilities, operated by state funds caring for members of the "defective, dependent, and delinquent classes," and no one had ever assessed the cost to the nation. It was a job that needed attention and it was undertaken in 1916. This study was conducted by the Bureau of the Census "in cooperation with the Eugenics Record Office."

In all, the 1916 Statistical Directory of State Institutions for the Defective, Dependent and Delinquent Classes covered institutions caring for ten different classes. One of these classes was the feeble-minded.

In the Statistical Directory, institutions for the feeble-minded were reported on in three groups: institutions for the feeble-minded (27), feeble-minded and epileptic (9), and feeble-minded, blind, and deaf (1). This study is unique in that for the first time administrative data are provided on the various institutions. It is limited in that it reports only on state institutions. Under the direction of Sam L. Rogers, it developed a format for data collection that influenced later demographic and administrative studies.

In the years between 1910 and 1916 four states (Colorado, Vermont, Oklahoma, and Wyoming) opened their first institution for the feeble-minded. This brought the total of state institutions to 37. Since the 1904 and 1910 census covered all "public" institutions, including in its study city and county institutions for the feeble-minded and wards for the feeble-minded in asylums for the insane, the 1916 data on population are not comparable to

earlier studies without some recomputation. This is not to the fault of the study, however, since the restricted purpose of this survey was to measure only the cost of operating the various state institutions. (Neither was it concerned primarily with the diagnostic labels placed on the inmates.)

Adding in the 1910 resident populations of the public institutions which were not included in the data on feeble-minded in the Statistical Directory, the number of feeble-minded inmates in the 40 public institutions in 1916 was about 27,665. This represents more than a twenty-five percent growth in six years. No data were gathered on private institutions in this study. But as rapidly as the inmate population was growing in the state institutions, the institutions were averaging only 96% of capacity according to this survey.

One marked trend which is demonstrated by this data is a shift in the ratio of males to females in the institutional population during this era. In 1890 there were 124.2 feeble-minded males for every 100 feeble-minded females in public institutions. In 1904 the ratio was 116.2 males/100 females. By 1910 the ratio had dropped to 113.4/100. In 1916 the ratio had nearly leveled out with 101.2 males/100 females. By 1923 that trend would stabilize and the ratio would remain 101.2/100.

The explanation for this trend from 1890 to 1916 lies not in changes in admission patterns. In all the studies from 1890 to 1923, males were more frequently admitted than females. The trend is explicable in looking at the discharge rates. During this period, the discharge rates for men were 30-40 percent greater than of women. A woman, at least until past childbearing age, was much less likely to be released from an institution than was a man. Examining the 1910 admission figures, it is evident that the only period in which female admissions were higher than male were the childbearing years 20-44. In the childhood, middle age and later years, male admissions were always higher.

In 1915, a total of 4,839 persons were admitted to state institutions for the feeble-minded. Of these, 1,101 were admitted to institutions for epileptic and feeble-minded. In that same year, 1,309 left the institution and 882 died while inmates. The net gain in institutional population was, then, 2,423 for the year.

The administrative data collected in 1915 for the year 1915 is the first attempt ever to estimate the costs incurred in operating state institutions for defective, dependent and delinquent classes on a nation-wide basis. The

value of the physical plants of institutions for the feeble-minded was calculated to be $24,358,804. This came to about $920 per capita institutional residents. The value of these plants per 100,000 population of the state shows wide variation in the relative financial outlays by various states, with the Massachusetts facilities valuing $53,332 per 100,000 persons in the state and North Carolina facilities valuing $4,608 per 100,000. While not as large as the relative difference among states in the value of their physical plants, the range of expenditures for maintenance and operation of state institutions was also large. The national average expenditure per inmate per month was $15.21, while Colorado was spending over $30.00 in its new institution opened in 1912 and Ohio was spending less than $12.00 to run the nation's largest institution for the feeble-minded. Similarly, patient/staff ratios varied widely, with Colorado's being the lowest (3.6/1) and Kentucky's the highest (11.8/1); the national average being 6.1/1. Breakdowns of institutional staffs according to job description showed that of the 4,165 employees, about one-sixth (687) worked in a professional or administrative capacity, about one-half (2,024) worked as attendants, nurses, or in other direct-care capacities, and the other one-third (1,454) worked as ancillary personnel (cooks, maintenance worker, etc.).

The facts and trends summarized here will be found entabled in more detail in the last section of this report. In examining the figures provided concerning the percent of total state governmental expenditures that the various states spent on state institutions, one finds the range stretching from 5.4% in Alabama to 30.5% in Massachusetts. The median percent of total state expenditures was 15.4%. It is of little wonder, then, that all subsequent reports on institutionalized populations of the feeble-minded would contain information on the cost of providing that care.

All Bureau of Census studies following the publishing of the Statistical Directory included administrative data (costs, employees, value of the institutions, etc.) as introduced in the 1916 study. In addition, the sections referring to the characteristics of residents were substantially amplified. The main force in this revision was the growing acceptance of a method of classifying feeble-minded persons.

The classification of "mental defectives" was first proposed by an Englishman, P. M. Duncan, as early as 1860. Duncan outlined three levels of feeble-mindedness:

> ...simpletons, imbeciles and idiots. The first are those feeble-minded, who have not been able to receive instruction in the ordinary manner, who do not possess the experience in life peculiar to those of their age in their social position, and who are said to be "dolts," "stupids," or "fools" by the uncharitable. They have nearly all the faculties to a certain degree, but indicate their alliance to the true idiot [emphasis provided] by their physiological deficiencies and general inertia of mind. They are to be distinguished from the backward and ill-taught (Duncan, 1860, p. 5-6).

While this terminology and modifications, particularly in regard to the highest grade for which "simpleton," "moron," "debile," and "feeble-minded" were applied by various authors, were much discussed by workers in the field, it was not included in the Bureau of the Census studies until the 1923 study. The reason for the delay was the lack of any systematic way of making such distinctions until the general adoption of the Binet scale as an instrument of categorization. The history of this process of acceptance of the scale in the United States as a measure of an innate and fixed level of intelligence is extremely interesting, but hardly within the scope of this review. Suffice it to say the Binet scale received a rather rapid success in the United States from the time it was introduced in the country in 1908, and by 1920 was accepted as a means of classifying mental defectives by the American Association for the Study of Feeble-mindedness. This association, previously the Association of Medical Officers of American Institutions for Idiotic and Feeble-minded Persons and to become in 1933 the American Associations on Mental Deficiency (AAMD), adopted the terms "idiot," "imbecile" and "idiot" to refer to the feeble-minded. In defining those terms the association relied on the scores derived from Terman's adaptation of the Binet scale. That definition will be outlined in the next chapter of this review covering the annual censuses of institutions for the feeble-minded and epileptics beginning in 1926. It was, however, first employed in the 1923 Bureau of the Census' report on the "Feeble-minded and Epileptics in Institutions."

The 1923 census of institutions also added institutions for the epileptic within its scope. The first such institution had been opened in 1894 by the state of Ohio. In 1898, Massachusetts and New Jersey opened institutions exclusively for epileptics, and one (North Carolina) had an exclusive department within its State Hospital. In enumerating the feeble-minded and epileptics, the 1923 census was structured so as to enumerate feeble-minded and epileptics as a single class as well as providing a breakdown according to primary "defect."

This allowed comparison with earlier studies which had included the colonies for the epileptic. This dual computation of the feeble-minded (later "mentally defective" and "mentally retarded") and the epileptic was continued in government censuses of institutions through 1959. At that time the distinction would be considered "no longer meaningful." From then on, the two types of institutions were considered as a single kind.

By January 1, 1923, the number of public institutions for the feeble-minded had grown to 66, 26 more than there were in 1916. The most notable growth during this period, however, was in the number of private institutions for the feeble-minded. Although no data were collected on private institutions in 1916, from 1910 to 1923 the number of private institutions for the feeble-minded grew from 28 to 73. Still, these 73 private institutions accounted for only 3,788 or 7.2 percent of the 49,096 total inmates of institutions for the feeble-minded and epileptic, up from 6 percent in 1910. In addition to the study of "Feeble-minded and Epileptics in Institutions," the Bureau of the Census conducted special reports on the "Insane in Hospitals" and "Paupers in Almshouses" in 1923. The returns from those censuses indicated that there were 6,887 feeble-minded without psychosis in hospitals for the insane and 12,183 feeble-minded in almshouses. The number of feeble-minded in almshouses had decreased by 25 percent from 1904 when 16,551 feeble-minded persons were in almshouses.

In addition to the demographic information contained in the 1923 report, the administrative data first collected for the Statistical Directory of 1916, were now made part of census of institutions for the feeble-minded. This information, however, was collected only for the state institutions. In the period from 1916 to 1923, the national average cost for maintaining a person in a state institution rose from $15.21 per month to $25.75 per month (or $16.74 controlling for inflation during that interval). During the same period the total value of institutions for the feeble-minded grew from about 24.4 million dollars to 41.5 million dollars, with the per capita value increasing from $920 to about $1,230. The increase in per capita cost of care occurred despite an increase in the patient-staff ratio from 6.1 in 1916 to 6.6 in 1923. The reader will find the results of these surveys of institutions for the feeble-minded summarized in the final chapter of this volume.

Much more could be said about the 1923 study of "Feeble-minded and Epileptics in Institutions." As a document, it contained nearly two hundred

pages of charts with brief descriptions. In the following years it became the standard methodology and format for subsequent annual reports on feeble-minded in institutions through 1946. Since its methodology and format became that of a series of studies beginning in 1926, they have not been discussed here, but will be in the next section of this review.

While primarily a statistical document and containing little narrative other than that which explained the tables of data, the introduction of the 1923 census contained a subsection entitled, "Value of the Study." In this section the author, whose identity was not recorded, stated:

> It must be borne in mind in considering the data herein presented that only a small part of the feeble-minded in the United States are in institutions established for their care. The vast majority are in the community, where many of them get along reasonably well and are partially or wholly self-supporting (Bureau of the Census, 1926, p. 14).

The fear of the feeble-minded seemed considerably subsided by the time this document was published in 1926. In fact, in terms of government enumerations of feeble-minded, the attitude seemed to turn in this period to a clear lack of interest. From 1926 on, the Bureau of the Census studies would be conducted routinely, with no change in methodology or format, until 1946. These studies became, as Lumburg and Morse (1947) so aptly characterized them, "essentially a bookkeeping project."

It is somewhat difficult to draw a clear line separating the study of 1923 from those which followed it. As has been said, in content and format the 1923 census of institutions is more similar to those which were undertaken subsequent to it, than it was to those which proceded. The distinction made here in linking it with earlier studies is made solely on the basis of the nature of its authorization. The 1902 act making permanent the Bureau of the Census authorized the Bureau to conduct one enumeration of special classes in institutions in conjunction with each decennial census. These occurred in 1904 in conjunction with the census of 1900, in 1910 in conjunction with the census of that same year and 1023 in conjunction with the census of 1920. As authorized by the act of 1902, these census were limited to one per decade.

In the years 1926, 1927 and 1928, the Secretary of Commerce authorized the Bureau to conduct three annual studies of "inmates of penal institutions and of institutions for the care of the mentally diseased and of feeble-minded and epileptics" (Senate Reports, 1929, p. 2). These reports had the advantage

in the eyes of W. M. Steuart, the director of the Bureau, of being able to show changes in administrative costs and population movement at regular, annual intervals. Beyond this, Steuart went to the Congress to get formal approval and funding of these annual censuses of institutions. That authorization was made as a public law on March 4, 1931.

Summary

Unlike the attempts to enumerate the total number of idiots and feeble-minded persons in the United States conducted in conjunction with the national census of 1840-1890, the 1904 and 1910 special censuses were concerned only with insane and feeble-minded in institutions. This change was required by the legislation which created a permanent Bureau of the Census.

In addition to the special census of institutionalized feeble-minded persons, a 1916 *Statistical Directory of State Institutions for Defective, Dependent and Delinquent Classes* was published by the Bureau in 1919. It contained the first administrative data (costs, staffing, etc.) collected on a nationwide basis on institutions. This type of data was retained in subsequent censuses by the Bureau.

In 1923 a census of institutions was conducted in conjunction with the 1920 national census. It included both patient and administrative data and was the first census to categorize inmates according to degree of feeble-mindedness. The methodology of the 1923 census was used for the annual studies of feeble-minded ("mental defectives" beginning in 1929) and epileptics in institutions which were conducted on an annual basis by the Bureau of the Census from 1926 - 1946.

ANNUAL BUREAU OF THE CENSUS SURVEYS OF MENTAL DEFECTIVES IN INSTITUTIONS, 1923-1946

In examining the demographic studies of feeble-minded persons which were undertaken prior to 1926, the reader is often struck with the sense of purpose of those undertaking the studies. That is not to say, of course, that the ideas expressed and the methods employed always represented positive directions in the enlightenment of America's citizenry concerning the nature of institutions for the feeble-minded and their inmates. These studies contained many forays into areas of research no longer considered fruitful. Many ideas expressed by the authors of these reports are today passe and at times disturbing and objectionable. Still these studies, as was the institutional movement they reflected, were governed by a clear sense of purpose. Like the ideas about the feeble-minded in general which were expressed in word and deed prior to the mid-twenties, these studies sought not only to describe the realities of feeble-mindedness and institutions for that class, but also to provide information to affect what were hoped would be better new realities. In short, these studies were perceived as having a clear reason for being conducted and they were carried out so that their purpose might be realized.

The demographic studies which followed those reported in the first part of this review appear to reflect a totally different attitude about mentally defective persons in institutions. While from 1904 until the present day studies of demographic characteristics of mentally retarded persons in institutions have generally been less flexible in providing useful information about those persons who have been relegated to long-term segregated care, it is the period from 1926 until the present in which the increasing rigidity most stands out. Spanning an era in which many options to institutionalization have been created, these studies continued to present year after year the same basic information about the ages, sex, and level of retardation of mentally retarded persons committed to the nation's institutions. While much of these data had

potential utility, seldom were they carefully analyzed. Relegated to library shelves, these studies produced as little interest as the institutions and inmates they had enumerated. The primary value of reviewing these studies now is to document statistically the development of institutional care for mentally retarded persons in the United States and the subsequent trends toward "deinstitutionalization."

The summary tables relating to institutional populations will be found in the last section of this report. It should be noted that from 1939 through 1959 the statistics reported by various surveys for the nation's total population of institutionalized mentally retarded persons have been estimated from the incomplete returns of the forms sent to each institution. Never in those years did the returns fall below 89 percent (1940) and estimates have been made by interpolating between years in which the individual institution did forward its patient movement statistics to the agency conducting the survey. After 1960 these estimates were made by the reporting agency. In some of the more specific movement categories (e.g., level of retardation of first admissions), the data presented in this review may be based on returns as low as 70%, but generally the annual reporting of these specific movement data fell in the 80-95% level of reporting. Since the incomplete returns are reported proportionally, it is believed that they are very nearly what would have been obtained had all institutions reported. The last complete government census of mentally retarded persons in institutions covered fiscal year 1969-1970. Since that time what demographic data there are on residential populations have been provided by nongovernment researchers, although these projects were frequently supported, at least in part, by federal government funds.

As has been pointed out, the census of "Feeble-minded and Epileptics in Institutions" of 1923 was conducted in conjunction with the 1920 census of the United States. The authorization for that census was derived from legislation passed in March 1902, which called for a census of "special classes" at the time of the decennial census, but restricted those enumerations to institutionalized populations.

Following the 1923 report on special classes in institutions, the Secretary of Commerce authorized the collection of statistics on "inmates in penal institutions and of institutions for the care of the mentally diseased and of feeble-minded and epileptics" (Senate Reports, 1929, p. 2). This

authorization, however, was limited to the years 1926, 1927 and 1928. In addition, the authorization was specifically limited to public institutions. In essence, these three studies of patient movement and administration costs were part of a trial period in which it was to be seen whether such data could be collected systematically on an annual basis. The limitation that these studies be only of public institutions did, however, make them more restrictive than the 1923 census of institutions upon which they were modeled, since the 1923 study included private as well as public institutions.

In 1929, W. M. Steuart, Director of the Bureau of the Census, approached the committee on Commerce of the U. S. Senate with a proposal to make permanent the institutional censuses which had been conducted under the authorization of the Secretary of Commerce since 1926. In addition to having the annual reports of patient movement and administrative expenditures made a permanent responsibility of the Bureau of the Census, Steuart was interested in having the authorization widened to include private as well as public institutions. Since such permanent authorization was not immediately forthcoming, subsequent annual authorizations were made by the Secretary of Commerce beginning in 1930. These special authorizations were made for the years 1930, 1931 and 1932.

On March 4, 1931 a bill was passed through Congress which included authorization of the Bureau to conduct annual enumerations of institutionalized persons in both public and private facilities. The first census conducted under the new law was "Mental Defectives and Epileptics in Institutions, 1933." Following the 1923 study, then, there was a period of two years (1924 and 1925) in which no census of institutions was conducted. From 1926 through 1932 these censuses were restricted to state institutions. From 1933 until the responsibility for the annual census of institutions for mental defectives and epileptics was given to the National Institute of Mental Health in 1947, the scope was again widened to include both public and private institutions.

The 1923 census of "Feeble-minded and Epileptics in Institutions" was one of those conducted in conjunction with the national decennial census. It is discussed here because in it was developed the methodology and the format for reporting data that were used in all subsequent Bureau of the Census studies of institutionalized populations. For the purposes of comparing data collected on an annual basis of institutionalized feeble-minded ("mental defectives" beginning in 1929) and epileptics, a more detailed look at the 1923 study will be included here.

The 1923 census of institutions introduced a methodology somewhat more sophisticated than that of the earlier studies. For one thing, "An individual schedule was used for each patient resident, admitted, discharged or died. On another schedule was reported the movement of patient population during the year" (Bureau of the Census, 1926, p. 13). These schedules are found in Appendix B. This technique allowed for computation of institutional data as well as cross-tabulation of specific occurrences (e.g., "readmissions") within special data categories such as age, degree of feeble-mindedness, and type of institution. In addition, "for the State institutions two other schedules were used to obtain data concerning administrative personnel, value and acreage of institution plants and financial operations" (Ibid.). The Bureau also developed a reporting method calculated to maximize the return of its four schedules: "At each institution all schedules were filled in by some one in authority, who was employed for that purpose by the Census Bureau" (Ibid.). The employment of institution personnel to collect the demographic data on individual institutions was discontinued after the 1923 study.

The 1923 census introduced a number of categories and definitions which had not been employed in previous censuses. To minimize problems associated with these, "instruction sheets accompanied the schedules giving instruction for supplying the data and defining the several terms used" (Bureau of the Census, 1923, p. 13). One change was that residents of institutions for the first time in this census were enumerated according to the levels of feeble-mindedness as measured by Terman's adaptation of the Binet scale. The appropriateness of using intelligence tests as a measure of intellectual potential was already a hotly debated issue during this period (the famous exchanges between Walter Lipmann and Lewis Terman appeared in the New Republic in 1922 and 1923). Still, the test was welcomed by the American Association for the Study of Feeble-mindedness, a group still dominated by the heads of the public institutions, as a means of categorizing feeble-minded persons. In fact, this group developed a Statistical Manual for the Use of Institutions for the Feeble-minded which was published in 1921. This manual contained the framework for the classification of "mental status" adopted by the Association in 1920. This classification scheme was used for the 1923 census of institutional populations and for the subsequent annual enumerations. The scheme included three levels of feeble-mindedness: "idiot," "imbecile" and "moron." They were defined as follows:

An "idiot" is a mentally defective person having a mental age of not more than 35 months, or, if a child, an intelligence quotient of less than 25.

An "imbecile" is a mentally defective person having a mental age between 36 months and 83 months, inclusive, or, if a child, an intelligence quotient between 25 and 49.

A "moron" is a mentally defective person having a mental age between 84 and 143 months, inclusive, or, if a child, an intelligence quotient between 50 and 74 (Bureau of the Census, 1923, p. 14).

The 1923 census introduced a number of other distinctions which had not been made in previous censuses. Prior to 1923 no distinction was made between first admissions, readmissions and transfers. These all had been treated as a single category, "admissions." The 1923 census defined these three types of admission in the following way:

A first admission is a person admitted to an institution who has not previously been a patient of an institution of the same class.

A readmission is a person admitted to an institution who has previously been a patient of an institution of the same class. A patient returned to an institution after discharge or indefinite parole would be counted as a readmission, but not one returned from ordinary parole.

A transfer is a patient who goes from one institution to another of the same class within the same State (Bureau of the Census, 1923, p. 13).

In addition to the new distinctions made in the 1923 census, a number of areas of information were carried forward from previous studies. The administrative data on costs and staffing of institutions were added in a form similar to the way they had been developed for the 1916 Statistical Directory. Included among the administrative data on costs were numbers of officers and employees and the amount spent for their salaries, expenditures for the maintenance of the institution, cost of provisions and value and acreage of the various institutions. The costs per resident of operating the institutions were computed and presented on a state-by-state basis. This information, however, was collected only from public institutions.

In all, the 1923 institutional census report contained several score of tables. This was permitted by the availability of individual data cards on each patient moving (i.e., being admitted, placed on parole, dying, etc.) during the year. While no report after 1923 presented data as extensively as did the

census report of that year, with the exception of 1926-1932, years in which the reports were conducted without special congressional allocations, the amount of information presented about categories of patient movement was much greater during the period from 1923-1946 than it had been previously or has been since. (Appendix B shows individual data cards for a number of movement categories, as well as the institution schedules for total patient movement and administrative data.)

As has been suggested in the discussion of the Bureau of the Census studies preceding the initiation of the annual studies, these reports in many ways reflect the societal attitudes regarding this class of American citizenry. Wolfensberger (1975) has referred to this period from the mid-twenties onward as a time of "momentum without rationales" in the history of the institutionalization process in the United States. Rationales, of course, were not totally absent, but clearly a change can be seen in the place of the institution in America. During the early part of the twentieth century the institution as a phenomenon became accepted. Because of this the "institutionalization movement," now integrated into societal patterns of thought did not require ongoing justification to secure its survival and growth. The rationale for the institution had become in essence to perform its function; that is, to provide a place where feeble-minded and epileptic persons could be "placed." The reason for the existence of institutions to care for the feeble-minded and epileptic was not at issue, and their function was not challenged. The institutions became storehouses of mental defectives and these studies of them became as Lümburg and Morse (1947) so fittingly termed them "essentially a bookkeeping project" (p. 3).

Penrose (1934) summed up the integrated role that the institution developed with the rest of the society during this period when he wrote:

> At present almost all states provide for institutional care. More frequent discovery of mentally deficient children in the schools; rapid increase in urbanization; emotional and similar stresses brought about by the proliferation of mechanical devises; the flood of mass immigration that has poured over the country, with the consequent clash of cultures and the personal and social disorganization of those most affected by the clash; economic, social, and emotional unrest associated with divorce, desertion, and non-support which has been so closely correlated with the breakdown of traditional functions of the family--have all contributed to these extensions of state institutions (1934, pp. 189-190).

In essence, the institution may be seen in this period as much an almshouse as a facility for the treatment of the feeble-minded. Penrose appeared to support this concept of the institution saying:

> Prior to 1910 it was maintained that all mentally deficient persons should be confined in institutions for life. At the present time, however, life segregation is applied only to those who are socially and economically unadaptable elsewhere (1934, p. 190).

In 1946, Hamilton, Mental Health Advisor for the U.S. Public Health Service, elaborated on this theme saying that:

> The primary purpose of most of these institutions [for mental defectives] is humanitarian. They relieve public agencies and the home of humble citizens of human burdens that otherwise do damage to their environments [by] hampering the normal activities of a family and developing a sense of shame and inferiority on the part of the other children (Hamilton, 1946, p. 452).

The information gathered in the Bureau of the Census surveys from 1923 through 1946 documented sizable changes in the use of public institutions for the residential care of mental defectives. In 1923 there were 66 public institutions for the mentally defective with a total resident population of 47,963. By 1946, 93 public institutions had a resident population of 115,928. During the period the number of residents in public institutions per 100,000 of the general population doubled, increasing from 39.3 to 81.6. Also growing nearly twofold was the average number of patients per institution (from 685 to 1,248). These few illustrative facts are sufficient to demonstrate the enormous expansion of the total institution model of care for mental defectives which occurred between 1923 and 1946.

The same year in which Hamilton outlined the "primary purpose of most of these institutions" (1946) the National Mental Health Act was passed and the responsibility for the annual census of institutions was transferred to the Public Health Service as specified in the Reorganization Plan No. 2 of 1946 (Code of Federal Regulations, 1957). The actual task of conducting the annual census would eventually befall the National Institute of Mental Health (NIMH) which was authorized by the National Mental Health Act (Public Law 79-487).

Summary

From 1926 through 1946, the Bureau of the Census conducted annual surveys of institutions for mental defectives, gathering information on demographic characteristics of the residents and aspects of the administration of these

facilities. From 1926 through 1932 this information was collected only from public institutions, with the scope of the surveys widened in 1933 to include private institutions as well. The methodology employed in these surveys was essentially that developed for the 1923 survey of institutions conducted in conjunction with the 1920 federal census. The analysis of data, however, was considerably less exhaustive than had been the case in 1923. As Lumburg and Morse (1947) noted, these surveys constituted "essentially a bookkeeping project," collecting the same basic demographic and administrative data at the end of each year. With the passage of the National Mental Health Act in 1946, the responsibility for these annual surveys was passed to the National Institute of Mental Health. That agency conducted its first institutional census in 1947. It will be considered in the next section.

ANNUAL INSTITUTE OF MENTAL HEALTH SURVEYS OF MENTALLY RETARDED PERSONS IN INSTITUTIONS, 1947-1970

The passage of Public Law 79-487 and the subsequent establishment of the National Institute of Mental Health (NIMH) had their roots in the two decades preceding World War II. In 1930 a Mental Hygiene Division was established within the Public Health Service. This agency was involved with state and local agencies during the 1930s in cooperative efforts to provide specialized services for the "mentally ill" (National Institute of Mental Health, 1950). The need for a specific agency within the federal bureaucratic structure which would emphasize research and training in this area was not advocated until 1940, when the American Psychiatric Association recommended the establishment of an institute with such a focus within the Public Health Service. While the outbreak of World War II temporarily interrupted these plans, the War's end brought renewed calls for the establishment of such an institute. Legislation toward this end was proposed in the summer of 1945 and the first congressional hearings were scheduled for the fall. In July of the following year President Truman signed into effect the National Mental Health Act.

The Federal Security Agency of the Public Health Service was specified in the legislation as having the responsibility of administering the Act and was authorized to establish a National Institute of Mental Health, although the formal establishment of the NIMH did not come until April 1949 (National Institute of Mental Health, 1950). This formal establishment represented basically an expansion of the Mental Hygiene Division of the Public Health Service, to which had been delegated the responsibility for the institutional censuses in the Reorganization Plan No. 2 of 1946.

The first census of "Patients in Mental Institutions" conducted by what became in 1949 the Biometrics Branch of the National Institute of Mental Health was undertaken in 1947. This branch of NIMH would retain responsibility for the enumeration of "patients in institutions for mental defectives and epileptics" until 1968, when this function was transferred to the Division of Mental

Retardation of the Social and Rehabilitation Service in the Department of Health, Education and Welfare.

The 1947 census of "Patients in Institutions for Mental Defectives and Epileptics" was published as Parts IV and V of a larger volume entitled Patients in Mental Institutions. Although the title of this volume was unchanged from earlier Bureau of the Census studies, the method of data collection had one major change from the earlier studies. In the earlier censuses, data were collected on line schedules which provided information on all patients in "movement." These line schedules yielded individual punch cards which allowed the cross tabulation of several categories (e.g., the cross tabulation of mental status and length of time instiutionalized for all discharges during a given year). Beginning in 1947 personal data on individual patients "in movement" were no longer collected. This, of course, created a relative inflexibility in the data acquired and limited the examination of the data to analysis by consolidation (i.e., populations of individual categories or cross categories could be consolidated but examination of, for example, the number of "morons" under five years admitted during the year from urban versus rural communities was no longer possible. (The 1947 schedules are attached as Appendix C.)

Commenting on the discontinuation of the line schedules with the 1947 institutional census Charles Lumburg, the statistician supervising that enumeration, stated that "data based upon individual case records made possible more detailed and relevant analysis than is possible under the present system, and for the present, the statistician can only envy the methods used in earlier surveys" (National Institute of Mental Health, 1947, p. 3). It was Lumburg's anticipation that:

> In the long run...the orientation [would] change again in the direction of greater emphasis on analysis of the data obtained in the annual survey as well as upon the basis of sampling surveys.... Attention [could] thus be directed to particular aspects of the overall problem such as questions of the reliability of basic records, the adequacy of statistical classifications, and characteristics of persons treated, the etiology of specific diseases, and the results of treatment (NIMH, 1947, p. 4).

This anticipated change of focus, at least in regard to the study of patients in the institutions for the mentally defective and epileptic (as opposed to those in hospitals for "mental disease"), was never fully accomplished. In general

the limitations of the 1947 study of institutions for mental defectives and epileptics were still very much evident in the study of institutionalized mentally defective persons twenty years later.

For the most part, then, the studies of patients in institutions for the mentally defective and epileptic conducted by the National Institute of Mental Health from 1947-1968 were continuations of the Bureau of the Census studies which preceded them. The fact that the individual line schedules had been discontinued was, for the most part, inconsequential in that the many possibilities for analysis through the use of these schedules seldom was undertaken extensively in preparing the Bureau of the Census publications prior to 1947.

As had been the case with the earlier studies, the National Institute of Mental Health censuses were standardized according to the categories outlined in the statistical manual of the American Association on Mental Deficiency. While this manual provided a model for data recording within institutions, it was not employed in all instances by all reporting facilities. This caused some slight variations in the comparability of information reported under the various categories. While these variations are not of great importance (especially in retrospect), they did affect the precision of the data reported and should serve to caution against a too literal acceptance of the specific numbers appearing in the reports. The following, cited from the 1947 report will serve as an example:

> The admissions data shown for California State hospitals include observation cases: i.e., patients who are seen for a few days and are then either released or formally admitted. Those admitted subsequent to observation are thus counted twice, which means that the number of first admissions reported constitutes an overstatement. Similarly, the number reported as discharges from California State hospitals includes patients discharged from observation in addition to those released from actual resident status (NIMH, 1947, p. 8).

In general, then, "state statistics...are not truly comparable due to the many procedural differences in the collection of the data" (NIMH, 1947, p. 8).

In addition to collecting information on the total number of patients in hospitals for mental defectives and epileptics and basic demographic characteristics of the persons residing in them,

> [t]he survey included inquiries on movement of population by sex of patient; first admissions by mental disorder [category of mental defect and type of epilepsy in the case of the mentally defective], age and sex; discharges by mental disorder, condition on discharge, and sex; number of persons comprising the adminis-

> trative staffs of mental institutions by occupation and sex; and the annual expenditures of mental institutions by purpose. All of this information was requested...of public institutions for mental defectives and epileptics; but only data on movement of population and first admissions were requested of...private institutions for mental defectives and epileptics (NIMH, 1947, p. 5).

While the information sought in this series of annual studies remained relatively constant (despite Lumburg's anticipation that changes would occur) certain categories were dropped or altered during the period from 1947-1967. From 1947-1949 figures for "excess population over capacity (overcrowding)" were reported as they had been in the Bureau of the Census Studies. In 1950, however, the computation of excess population over normal capacity was dropped. The reason for this change was given in the report for 1952:

> Data are not presented on overcrowding of public institutions for two reasons: One, many institutions for mental defectives and epileptics maintain waiting lists and tend to admit patients as space becomes available. Secondly, the standards upon which rated capacity is measured vary so widely both in time and among states as to make comparisons misleading (NIMH, 1952, p. 10).

Prior to 1952, the annual censuses of institutions reported both the population of residents at the beginning and at the end of each year, but provided no average daily resident population figure. Beginning in 1952 the average daily population was also included in the reports. It is this figure which is presented in the summary of trends in institutional populations to be presented later in this volume. For the years prior to 1952 the figure which appears represents the number of patients at the beginning of each year.

In 1960 the terminology applied to the subjects of these annual reports began to undergo specific changes. The first change occurred in 1960 when the persons studied no longer were referred to as "mentally defective and epileptic," but simply as "mentally retarded." The first specific distinction between the feeble-minded and the epileptic had been made in the Statistical Directory of 1916.

It should be pointed out to the reader that after 1936 some of the data regarding resident characteristics refers only to "feeble-minded" among "feeble-minded and epileptics." A separate analysis of feeble-minded persons in institutions for the feeble-minded and epileptics and epileptics in these institutions was made beginning in 1936. These data on patient movement in

these institutions after 1936 were reported on each class separately. Administrative data were consolidated in the report. The rationale for this approach to computing administrative data stemmed from the fact that admissions to either type of institution for the feeble-minded or the epileptic was never clearly determined by the existence of one or the other of the disorders. In reality the designation of institutions specifically for epileptics was never widespread and as a trend lasted only a few years, although a number of "epileptic colonies" retained their title as such after they had begun to function as general facilities for mental defectives.

The first institution specifically for epileptics was the Ohio Hospital for Epileptics which opened in 1893. In 1894 New York State opened the Craig Colony for Epileptics. Massachusetts and New Jersey followed this lead in 1894. A number of other states continued the trend towards separate colonies for epileptics during the period between 1900-1920. In all during the period between 1893 and 1920, twelve states had created institutions exclusively for epileptics. However, three of those states already by 1920 had consolidated these colonies for epileptics with adjoining institutions for the feeble-minded or had admitted feeble-minded persons to the colonies, changing the name of the institution to reflect the admission of both classes. During the period covered by the Bureau of the Census reports on Feeble-minded and Epileptics in Institutions beginning in 1923, the distinction among these types of institutions was no longer clear enough to warrant separate analysis of patient movement and administrative data. From 1923 through 1935 feeble-minded and epileptic persons were treated as a single group for the purposes of collecting and reporting institutional data. In 1936 "in compliance with the suggestions of the American Psychiatric Association (APA) and the American Association on Mental Deficiency (AAMD), an entire separation of mental defectives and epileptics [was] made in the report" (Bureau of the Census, 1936, p. 1).

While movement data (e.g., readmissions and discharges) were provided in a section of consolidated data, for analyses involving characteristics of residents, the mental defectives were categorized according to mental level while the epileptics were reported by clinical diagnosis within the categories of "symptomatic" or "idiopathic" epilepsy. By 1959, however, fewer than half the states were reporting any epileptic patients, only nine states were

reporting over two hundred epileptic residents, and fewer than eight percent of all residents of public institutions for the mentally defective and epileptics were considered to have epilepsy as the primary diagnosis. The following year (1960) the distinction between the two groups was eliminated. According to the 1961 report (NIMH, 1961, p. 5), "for statistical presentation of data, and in light of the American Association on Mental Deficiency's Revised Medical Classification, it was believed that the distinction was no longer meaningful."

The new terminology and categories of mental retardation outlined in the "Manual of Terminology and Classification in Mental Retardation" (Heber, 1961) brought about other changes in the classification of mentally retarded persons, changes that were over a three-year period incorporated into the NIMH census of institutions. The new terminology applied to levels of mental retardation and their definitions are presented below as they were outlined in the introduction of the NIMH studies beginning in 1961.

Classification	Degree of Deviation in Standard Deviation Units	Range of Categorization in Standard Deviation Units	Corresponding IQ Scores (SD = 15)
Average Intelligence	<1	+1.00 to -1.00	85-115
Borderline	-1	-1.01 to -2.00	70- 84
Mild	-2	-2.01 to -3.00	55- 69
Moderate	-3	-3.01 to -4.00	40- 54
Severe	-4	-4.01 to -5.00	25- 39
Profound	-5	Less than -5.00	Less than 25

This classification system was first employed with first admissions in 1961. In 1963 it was adopted for reporting on all mentally retarded patients, those in residence as well as those being admitted.

With the exception of the variations noted above and a few other minor changes, some of which will be mentioned later, the annual census of residents of institutions was carried out and reported in a consistent format from 1947 through 1966 as part of the volume Patients in Mental Institutions. In 1967 and 1968 similar surveys were conducted by the National Institute of Mental Health, but the results were published only as "Statistical Notes" and "Current Facility Reports," much abbreviated pamphlets containing tables of basic population and movement data regarding public institutions for the mentally

retarded. The 1968 study was the last of the NIMH surveys of institutional populations. The results of these censuses, as well as those conducted by the Bureau of the Census will be presented later in this paper, combined with subsequent data compiled and published by other sources.

On January 1, 1967 a Division of Mental Retardation (later the Division of Developmental Disabilities) was formed within the Public Health Service to bring together under one authority the wide range of programs dealing with mental retardation within that agency. In August of that year the Division was transferred to the Rehabilitation Services Administration of the Social and Rehabilitation Service. Part of the responsibility of the Division became the continuation of the annual survey of populations of institutions for the mentally retarded.

In 1969 the Division of Mental Retardation conducted its first survey, as part of its Mental Retardation Reporting Program. In comparison to the Bureau of the Census and NIMH censuses which preceded it, it was extremely brief, collecting only the most general information on patient population, movement categories and administrative data of the individual public institutions. The results of the survey for fiscal year 1969 and fiscal year 1970 were completed and published as "Current Facilities Reports: Residents in Public Institutions for the Mentally Retarded." The questionnaire used in these studies is attached in Appendix C. The results of these surveys were also contained in the Mental Retardation Source Book, published by the Office of Mental Retardation Coordination in September 1972. This document contained not only the results of the surveys of the Office of Developmental Disabilities, but also concurrent surveys by the National Center for Health Statistics ("Surveys of the Master Facility Inventory"), Office of Research and Statistics of the Social Security Administration ("Survey of Institutionalized Adults"), and several other government agencies involved in residential and treatment programs for mentally retarded persons.

Beginning in fiscal year 1970-1971, the government's annual collection and dissemination of information on the numbers and characteristics of residents in institutions for the mentally retarded ground to a halt after nearly fifty years of interrupted processing. For fiscal year 1971 data were collected, analyzed and prepared for publication, but the Division of Mental Retardation was never authorized to publish the results (Mental Retardation Biometrics

Program, no date). Surveys were also conducted by the Division for fiscal years 1972-1975. These surveys, however, lacked a completeness of returns sufficient to make the data of any use. The rate of return of these surveys varied somewhat from year to year and state by state, but seldom were returns completed by more than sixty percent of the public residential facilities in any given year. No substantial follow-up procedures were employed by the Office of Developmental Disabilities to increase that rate of return and according to the Office the surveys would "receive a low priority until the publication and distribution problem can be overcome" ("Mental Retardation Biometrics Program," no date, p. 4).

From 1947 to 1967 the growth in the number of retarded persons in public residential facilities continued to increase each year. From 116,278 residents in the 94 public institutions in operation in 1947, the population increased in twenty years to 194,650. The number of public institutions grew to 162 in this same period. In the following three years the number of institutions continued to increase, reaching 190 in 1970. But beginning in 1968 the total population of these facilities began to decrease. In 1970 that number had fallen to 186,743.

Summary

Beginning in 1947 the responsibility for conducting the annual surveys of institutions for the mentally retarded was passed to the Biometrics Division of the National Institute of Mental Health. For the most part this agency maintained the structure of the Bureau of the Census surveys, although the methodology of the earlier studies was somewhat simplified. The major change in methodology involved the discontinuation of the use of "line schedules" for individual patients in movement. The NIMH surveys were conducted through 1968.

In 1969 the responsibility for continuing the annual surveys was shifted to the Division of Mental Retardation of the Social and Rehabilitation Service. This agency greatly abbreviated the survey, collecting only the most general information on total institutional population, patient movement and program costs. Survey results were reported for the fiscal years 1969 and 1970, but no data were reported for subsequent years, even though the survey questionnaire was mailed to public institutions through fiscal year 1975.

SURVEYS OF MENTALLY RETARDED PERSONS IN INSTITUTIONS CONDUCTED IN THE 1970s

After nearly fifty years of uninterrupted annual surveys of institutions for the mentally retarded, in the early 1970s the federal data collection system ceased effective operation. It is interesting to note that this occurred immediately following the halt of a century and a quarter of steady growth in the number of persons committed to public institutions for the mentally retarded. A discussion of the social forces which sufficiently impinged on the residential service system creating in recent decades a steady growth in the parallel philosophies of "deinstitutionalization" and "normalization" has been discussed often in recent years and is beyond the scope of this paper. Suffice it to say that it slowly became recognized that institutions were far more atypical among social settings than their residents were among human beings. By 1968 the number of persons residing in public institutions for the mentally retarded began to decrease. Although this trend would continue into the 1970s, it occurred without an institutional census apparatus which could measure the change. This void, however, to some extent has been filled by the National Association of Superintendents of Public Residential Facilities (Scheerenberger, 1974; 1976; 1978) and the Developmental Disabilities Project on Residential Services and Community Adjustment (DDP) at the University of Minnesota (Hauber, Kudla, Wieck & Kirwin, 1979) which have surveyed and reported the trends in institutional populations and characteristics of the residents during the 1970s.

The first census of institutional populations reported by Scheerenberger (1965) was one conducted for the American Association on Mental Deficiency (AAMD) for the year 1964, "accurate as of November 1, 1964" (Scheerenberger, 1965, p. 4). Most of the survey can be seen as a duplication of "Patients in Public Institutions for the Mentally Retarded" conducted by the National Institute of Mental Health for that same year. Although the survey reported

by Scheerenberger did contain information concerning types of educational programs available for the residents of the institutions which was not included in the NIMH survey, the major value of this study may be in the fact that it provided a reliability check on the survey procedures employed in the federal censuses of this same period.

When the AAMD survey is used as a standard of reliability for the NIMH study of the same year (or vice versa), one is struck by the congruence among the data of the two studies. Some major data categories are cited here as examples:

Category	NIMH	Scheerenberger (1965)
Public Institutions	135	135
Patients on Books	191,786[1]	192,493[2]
Employees (full-time)	74,128[3]	76,751[4]

Generally, then, each of the two comparable studies seemed to support the reliability of the other. As is so often the case with separate studies of the same phenomenon, there were minor discrepancies influenced by differing definitions and time frames. To the degree that the data differed, once again the need for a standardized methodology for defining and collecting basic demographic information which can be used in the analysis of change over time was highlighted. Still, the existence of these two very similar studies conducted at nearly the same time demonstrates that this type of population data can be collected with a high degree of reliability. Later, when the federal government's annual census process broke down in the early seventies, the need to interpret studies with slightly varying definitions and methodologies would again cause some concern about the comparability of results. One-shot studies generally have been adequate in the collection data for a point in time, but

[1]December 31, 1964, Residents in institution + "on visit" + Unauthorized absence.

[2]November 1, 1964, "Actual population"

[3]June 30, 1964 (with an average monthly growth between June 30, 1964 and June 30, 1965 of approximately 430 employees per month)

[4]November 1, 1964

they have been less useful in analyzing trends in a service system that is rapidly undergoing change. Fortunately three of the "non-annual" studies conducted in the 1970s were carried out using virtually the same methodology (Scheerenberger, 1974; 1976; 1977), providing adequate standardization of the data collected on public institutions and their populations in recent years, although the set of institutions included in the most recent of Scheerenberger's surveys created rather serious problems which will be discussed subsequently. As the reader will note in comparing Scheerenberger's schedule contained in Appendix D with the NIMH schedule in Appendix C, most of the data are based on similarly defined categories of patient movement, administrative information, resident characteristics and time frame.

Scheerenberger's 1974 report was sponsored by National Association of Superintendents of Public Residential Facilities. This study was the third in a series sponsored by the Association, the two previous ones being by Rosen and Bruno (1970) and Rosen and Callan (1972). Like Scheerenberger's 1974 study, however, these studies failed to elicit complete returns from the public residential facilities surveyed. In Scheerenberger's 1974 survey, for example, 191 of 235 (81%) returned either the long form original questionnaire or the short form follow-up questionnaire. The data acquired from the Rosen and Bruno (1970), Rosen and Callan (1972) and the Scheerenberger (1974) reports did, on the other hand, permit an analysis of trends in patient movement among the 176 public facilities which had responded in all three of the studies. No attempt was made to estimate residential population of those institutions from which no response was received. Such attempts would have been subject to unknown error, given the changes occurring at this time in the provision of residential services for mentally retarded persons.

In 1976, however, Scheerenberger was able to survey all of 237 operating public residential facilities in the United States. This effort, authorized and supported by the President's Committee on Mental Retardation as well as the National Association of Superintendents of Public Residential Facilities for the Mentally Retarded, also produced retrospective reports of resident population data for the fiscal years 1971-1972 through 1975-1976. This survey, then, provided some tentative closure in the gaps in annual population figures for mentally retarded persons in public residential facilities which were created when the Office of Developmental Disabilities was unable to continue its annual survey of residents in institutions for the mentally retarded.

For his 1976 study of characteristics of public institutions for the mentally retarded, their programs and their residents, Scheerenberger developed a 33-item long questionnaire and a short form questionnaire of six items to use as a follow-up instrument. The long form of Scheerenberger's instrument involved six primary areas of inquiry: basic demographic data; population movement; placement/post-placement procedures and services; resident programs; parental participation; and administration, including budgeting and staffing (Scheerenberger, 1976, p. 1). The short form omitted patient movement, placement, and programming data, emphasizing basic demographic and budgetary information. The two forms are shown in Appendix D.

Of the 237 public residential facilities surveyed by Scheerenberger in 1976, 70 percent returned the long form and 30 percent the short form. As was the case with the government studies after 1960, the definitions of categories employed in this survey were those of the American Association on Mental Deficiency. Although not perfectly analogous to the Bureau of the Census and National Institute of Mental Health studies prior to 1970, Scheerenberger's efforts provided some continuity to the effort to account for those persons living in institutions for the mentally retarded. Unfortunately, since only 70 percent of the residential facilities surveyed completed Scheerenberger's long form, most of the data collected in his study represents only a portion of the total number of institutions. That percentage was very nearly the same as the percentage (66%) which completed the long form in Scheerenberger's 1974 survey. In 1974, however, the follow-up short form was completed by only an additional 16 percent. Since the long form contained most of the questions regarding resident movement, the low completion rate may make these data less accurate than those collected in the Bureau of the Census and NIMH studies. Resident movement data from these latter studies were usually based upon complete returns from more than 80 percent of the public institutions for the mentally retarded.

For fiscal year 1976-1977, Scheerenberger again surveyed the nation's public residential facilities for the mentally retarded. This study was supported by a federal grant to the Developmental Disabilities Project on Residential Services and Community Adjustment (DDP) at the University of Minnesota under a grant from the Office of Developmental Disabilities, U.S. Department of Health, Education and Welfare. Scheerenberger was contracted by

the project to conduct this survey based on his previous experience and success with similar studies of institutional populations. Minor changes were made in Scheerenberger's 1977 questionnaire to make it congruent with the concurrent national census of community residential facilities for the mentally retarded conducted by the Developmental Disabilities Project. In addition to a 31-item questionnaire, a five-item short form was developed by Scheerenberger for a follow-up inquiry to facilities failing to respond to the long form. As with previous studies, Scheerenberger solicited his information directly from the superintendents and program directors of the state residential facilities known to the National Association of Superintendents of Public Residential Facilities for the Mentally Retarded. This 1977 survey received long form responses from 218 (83%) of the 264 facilities known to be operational during the year and short form responses from 46 (17%), for a 100 percent participation rate (Scheerenberger, 1978).

Scheerenberger's 1977 survey expanded the universe of public institutions with the inclusion of twenty mental hospitals and mental health centers which were known to have mentally retarded residents. The use of institutions for the mentally ill in providing residential space for mentally retarded persons has been noted since the first institutional census of 1880. Because of the complications this practice has caused in data collection, researchers have tended to conduct their surveys on the basis of institution type rather than attempting to enumerate mentally retarded persons in all institutions. In straying from this convention Scheerenberger's 1977 report creates a major problem in interpreting the survey results. The main difficulty is that the census included only a small fraction of the mental hospitals with mentally retarded residents and mixed the number of mentally retarded persons in institutions for the mentally ill with those in institutions for the mentally retarded in such a way that the two groups cannot be separated. This creates the impression that the number of public residential facilities grew substantially from June 30, 1976 to June 30, 1977 when in fact what grew was the universe of facilities included in the survey. Other problems naturally follow. Scheerenberger (1978) reported:

> The rate of total resident population decrease between FY (fiscal year) '75-'76 and FY '76-'77 was only 1.36%. This result supports last year's conclusion that the number of mentally retarded persons being returned to the community is decreasing.

> This year's figure, however, was substantially less than anticipated and markedly below that reported for FY '71-'72, FY '72-'73, FY '73-'74, FY '75-'76: 4.37%, 4.33%, 4.32%, and 3.44%, respectively (pp. 3-4).

This conclusion, however, was based on an increased base for institutional population for the period covered. This made the computed percentage decrease in the population of institutions for the mentally retarded considerably less than it would have been had the same universe of institutions used in earlier surveys been used in 1977. (For the reasons stated above the reader will not find the population of institutions for the mentally retarded reported in Scheerenberger's 1977 institutional survey included in the summary of institutional population statistics in the last section of this review.)

The preceding discussion of Scheerenberger's universe of institutions poses the question, "How many mentally retarded persons are in institutions primarily serving the mentally ill?" There have been ongoing attempts to answer this question since the first institutional census of 1880. There are serious problems inherent in the simplicity of the question which have made it difficult to study. Put simply, the problem is: Though many residents of mental hospitals may be seen as functionally mentally retarded, is that retardation secondary to mental illness or a primary disability?

The number of mentally retarded in public institutions for the mentally ill has been recorded since 1880. The reported numbers of these persons grew from 1,141 in 1880 to 18,829 in 1923. By 1961 the number had peaked at 41,823 (based on reports of 95 percent of the 285 known public facilities). From then on, like the population of the public institutions for the mentally ill as a whole, the number began dropping, although not as rapidly as did the total institutional populations. In 1961 mentally retarded persons made up 8.4 percent of the total population in institutions for the mentally ill. By 1970 they composed 9.0 percent, and by 1973 they were 12.2 percent or 30,237 of the 248,518 residents of these institutions. The total number of mentally retarded residents of these institutions in 1973 was 92.4 percent of the 1969 total. This rate of decrease was by far the lowest of any diagnostic category within the mental hospitals. In the few years in which such data were reported, approximately 25 to 40 percent of the mentally retarded persons in mental institutions were judged to be without psychosis in addition to the mental retardation. Mental institutions, then, have been and remain a significant factor in

residential service system for mentally retarded persons. (Those interested in this topic are directed to the series of surveys of population demographics relating to public mental hospitals which paralleled those studies reviewed in this volume. More recent information is available in the Statistical Note Series of the Division of Biometry of the National Institute of Mental Health, Department of Health, Education and Welfare.)

Scheerenberger's 1977 study was designed to be comparable to a concurrent study of community residential facilities conducted by the Developmental Disabilities Project on Residential Services and Community Adjustment (Hauber et al., 1979; DDP, 1979). Community residential facilities were differentiated from public facilities in this coordinated effort on the basis of the latter's being a "state supported and administered facility" versus the former's independent operation under the restrictions of state licensure and/or contract as a service provider for mentally retarded persons. A brief discussion of the results of this coordinated effort will be made in this volume since basic data from these studies are not provided in the historical summaries in the final section.

The 1977 survey of community residential facilities found 4,427 facilities providing residential services to 62,397 mentally retarded persons on June 30, 1977. This compares with approximately 150,000 residents in public residential facilities. Despite this status of utilization of the two types of facilities, the surveys produced ample evidence of the growth of community residential placements and the concurrent decrease in the use of public facilities.

From June 30, 1976 to June 30, 1977, 27,530 persons were admitted (both first admissions and readmissions) to facilities for the mentally retarded. Of these, 63 percent were admitted to community facilities (17,398), while 37 percent were admitted to public facilities. Among the 24,153 releases (live releases and deaths), 59 percent (14,244) were from public facilities while 41 percent (9,909) were from community facilities. It is clear that at the present time the growth in the residential service system is taking place among community residential facilities which tend to have younger and less seriously handicapped residents.

One of the more notable, and expected, differences found between public and community residential facilities was in their size. While public residential facilities in Scheerenberger's survey averaged 585 residents, the community

facilities averaged 17 residents. Still, while nearly three-fourths of all community residential facilities contained ten or fewer residents, over one-half (51%) of the persons in community facilities for the mentally retarded lived in residences with more than 30 other persons. "Normalization" in the sense of living in family-sized units, then, it would seem is still far from realized even though fewer persons are residing in public residential facilities.

The Developmental Disabilities Project on Residential Services and Community Adjustment (DDP), in addition to the study discussed above, conducted a survey of Mentally Retarded People in State-operated Residential Facilities: Year ending June 30, 1978 (Krantz, Bruininks & Clumpner, 1978). Unlike previous surveys, this effort collected data from the central records of each state on the rationale that "residential service to mentally retarded people is, within the U.S. Constitutional framework, basically a state responsibility. The states may discharge the responsibility with different mixes of direct and regulated services, but their operation of residential facilities as such is clear-cut definable operation" (Krantz et al., 1978, p. 3).

Every state and the District of Columbia provided information, through use of a mailed questionnaire and extensive telephone follow-up. The survey obtained nine items of information regarding numbers of residents, patient movement categories and per diem costs for facilities whose primary mission was residential service to mentally retarded people, and for people with a primary diagnosis of mental retardation in facilities whose primary mission was service to other populations. Information was obtained regarding 374 facilities, of which 236 were in primary service to the mentally retarded.

This survey was complete in its coverage of the states, but quite restricted as to the amount of information sought. It also distinguished two types of facility, those primarily for mentally retarded persons and those other public facilities in which some number of other mentally retarded persons might be residing. Additionally this project demonstrated it was possible to disseminate its findings within five months of the close of the fiscal year upon which it reported, compared with an average of two to three years for the Bureau of the Census and NIMH surveys. The questionnaire (attached in Appendix D) was designed to collect information comparable to that secured in previous surveys.

Recognizing that "in significant numbers, mentally retarded people are given residential service by many states in facilities that are not designed

exclusively or even primarily for the mentally retarded" (Krantz et al., 1978, p. 3), the DDP survey of 1978 made a distinction between residents of "state residential facilities for the mentally retarded" and "persons whose primary diagnosis was mental retardation" in "other state residential facilities" (Ibid., p. 10). The numbers reported under the former category provided population data comparable to that of other studies reviewed in this volume. The latter category provided considerably less reliable information since "in many states, an agency other than the one initially contacted by the Project has responsibility for facilities that do not primarily serve the mentally retarded, and sometimes such persons are not officially 'tracked'" (Ibid., p. 12). In commenting on this category of data the authors of the report noted that "Four states were not able to provide a figure, and nine others reported estimates" while 23 states reported that "they had no significant number of mentally retarded persons [primary diagnosis] in PRF/other [state residential facilities not primarily for the mentally retarded] placement" (Krantz et al., 1978, p. 12).

The findings of the DDP survey of 1978 indicated that approximately 10,000 persons with a primary diagnosis of mental retardation were found in public residential facilities other than those primarily for mentally retarded persons. This represented about 7 percent of the slightly more than 150,000 mentally retarded persons reported to be in state residential facilities. As has been consistently found in comparisons of institutions for the mentally retarded with those for the mentally ill, the ratio of admissions and discharges to the average daily census of mentally retarded residents was much higher for the PRF/other category than for the facilities primarily for the mentally retarded (4.7 times as high for admissions and 5.5 times as high for live releases). Simply put, there was a much higher turnover in facilities not designated as residential facilities primarily for the mentally retarded. Whether this well-documented tendency, which can be noted throughout the history of patient movement documentation, derives from a difference in the characteristics of residents or from philosophies concerning treatment (or both) is not easily assessed since descriptions of mentally retarded persons in mental hospitals have never gone beyond the designations of "mental retardation with or without psychosis."

One of the more interesting aspects of the DDP survey was its simplicity. Instead of surveying nearly four hundred separate facilities it was able to

collect basic patient movement and administrative data from the state agencies directly responsible for residential services for the mentally retarded. The reliability of these data was not, however, investigated through concurrent surveys of the individual institutions in some or all states. This reliability will need to be tested before surveys such as that by the DDP become a primary method of collecting basic population data on persons in residential facilities for the mentally retarded.

Another problem with the DDP survey was that it provided no basic descriptive information on the populations of the various residential settings for mentally retarded persons (i.e., breakdowns by age ranges, level of retardation, multiple disabilities, etc.). Program planning requires some data source which will provide policy makers with this information. The development of mechanisms for collecting such data will need serious consideration in the near future. Only one federally sponsored survey (Scheerenberger, 1978) collecting and disseminating any of these basic descriptive population data has been conducted in the 1970s.

The reader will find the results of the institutional surveys conducted between 1970 and 1978 summarized in the final chapter of this volume. Among the more notable features of the period were the sharp drop in the population of public institutions for the mentally retarded (from 186,743 to 139,432) and the sharp increase in the cost of providing residential services. In 1970 it cost an average of 4,635 dollars (in 1967 dollars, $3,985) to maintain a resident for a year in a public institution. By 1978 that cost had rocketed to 18,287 dollars (in 1967 dollars, $9,378).

Summary

During the 1970s (with the exception of fiscal year 1969-1970) all published surveys of basic population and administrative data of institutions for the mentally retarded have been conducted by non-governmental projects. While most of the data have been comparable, the surveys have varied somewhat in scope and in the universe of institutions surveyed. The variations in methodology as well as the realization that no mechanism presently exists to collect information about institutionalized mentally retarded persons in an ongoing basis suggests a need for a governmental commitment to a systematic method of collecting such data at regular intervals.

RESIDENTS OF INSTITUTIONS FOR THE MENTALLY RETARDED: A SUMMARY OF TRENDS, 1880-1978

In this summary chapter, demographic and administrative trends among institutions for the mentally retarded are reviewed. The sources of the data reported herein have been discussed in the previous chapters.

Public Institutions

Discussion of the growth of public institutions for mentally retarded persons for the years 1880 through 1923 appeared in the first of this review. Some of these population data will be referred to briefly again here, and will be contained in the summary tables which are included in this section.

By the time that the annual census of institutions was begun by the Bureau of the Census in 1926, the institution for the "feeble-minded" was in a rather ambiguous position in American society. The justifications for its establishment, based on a prevailing opinion heretofore that the feeble-minded were somehow a serious social menace, were less often pronounced than they had been in previous years. Still, by this time (the 1920s) the institution as a means of providing for the feeble-minded had become established and continued to grow, to repeat Wolfensberger's phrase, on "momentum without rationales" (Wolfensberger, 1976, p. 69).

But it is equally important to note that during the period preceding the Second World War, there was a steady growth in special services directed toward working with feeble-minded children in their communities. Still it was not until the end of World War II that the number of "mentally defective" children receiving special education in public schools surpassed the number housed in public institutions for "mental defectives" (U.S. Office of Education, 1954). It was not until the mid-1950s that special education was serving more mentally retarded persons than were the public institutions (Mackie & Robbins, 1960). These are important facts to remember when attempting to understand the social

context in which the institutionalization movement continued to grow into the 1960s. The relatively small influence of special educators until the 1950s was also shared by social welfare workers, who during the depression and World War II were in a low growth industry. With the end of the war and the prosperity which followed, both special education and social work began growing rapidly. As social and moral enterprises, both of these were interested in keeping mentally retarded persons in the community, usually with the conviction that it was in the best interests of their clients. But until these community-based forces had gained a persuasive strength equal to those who supported the institutional alternative, institutions continued to grow without significant resistance from society. This was clearly the case into the years following World War II.

While the eventual prevailing philosophy of normalization was many years away at the end of World War II, it had its beginnings in the reaction to the unrealized concern about the mentally retarded following the late nineteenth and early twentieth century, during which time the mentally deficient had failed to live up to society's worst fears about them. In retrospect it seems that the growth of the institution which continued unabated beyond the 1920s is probably as easily explained by the fact that it was already a functioning option in providing for retarded persons, as by any inherent appeal it had to the attitudes of the general populace regarding feeble-minded persons.

As years went by the emphasis of the field of mental retardation, which prior to the late twenties had been placed nearly exclusively on the provision of institutional accommodations, began to shift towards other ways of providing for feeble-minded persons within the community. The institution became the last resort: a place for the unfortunate among the unfortunate. Still, while physically isolated from the mainstream of American society and becoming less prominent among America's social problems, the populations of American institutions for the feeble-minded continued to grow. The growth was not rapid enough to be highly visible (it averaged fewer than seventy persons per state per year from 1923-1946), but it was steady. By 1947 institutions for the feeble-minded contained two-and-one-half times as many inmates as they had twenty-five years earlier, in institutions which had grown in numbers only from 66 to 94 during this period.

These rates of increase continued through the post-war years into the fifties and through most of the sixties. It is difficult, however, to compare

the population trends of the forties with those of the fifties and sixties in terms of the tendency to institutionalize mentally retarded persons. Major demographic changes in the population of the U.S. must be noted. From the mid-fifties until the late sixties the children of the baby boom moved through the age range at which mentally retarded persons are most at risk of institutionalization (i.e., school age). Because of the population bulge at these ages, comparisons between the forties and the late fifties and sixties are not perfectly analogous. Still, the fact remains that institutional populations continued to grow steadily through 1967, despite tremendous increases in community-based educational and social services.

In 1968, however, public institutions for the mentally retarded had a lower average daily resident population than they did the previous year, and the same can be said of each year since. Table 5 shows the growth in the population of public institutions from 1880 through 1967 and the subsequent rapid decreases in total population through 1978.

The population of institutions prior to 1947, the year in which the annual census became the responsibility of the National Institute for Mental Health (NIMH), increased far more rapidly than did the number of institutions. This continued to be the case through the 1950s. Beginning in 1961, however, this trend was halted and gradually the number of public institutions began to increase at a higher rate than did the total population of these institutions. In 1950 the number of public institutions (96) was 143 percent of the number which had existed twenty-eight years earlier in 1922 (66). In 1978 the existing 236 public institutions were 246 percent of the number in operation twenty-eight years earlier in 1950. The growth in the total number of public residential facilities for the mentally retarded from 1880 through 1978 is shown in Table 6 (see page 72).

The result of this trend was eventually to lead to a lower average population among public institutions. As shown in Table 7 (see page 73), this drop in average residents per institution has continued every year since 1960, from 1960's high of 1,516 persons per institution to an average in 1978 of 591, the lowest reported average since 1910.

While the average number of residents per institution began to level off and then slowly fall in the late fifties and early sixties, the number of residents in these institutions per 100,000 of the general population continued

Table 5

Total Population of Public Institutions for the Mentally Retarded
1880-1978

Year	Population	Year	Population
1880	2,429	1930	68,035
1881	--	1931	72,565
1882	--	1932	76,726
1883	--	1933	84,131
1884	--	1934	87,383
1885	--	1935	89,760
1886	--	1936	91,754
1887	--	1937	93,772
1888	--	1938	97,209
1889	--	1939	101.396
1890	5,103	1940	106,944
1891	--	1941	109,537
1892	--	1942	110,959
1893	--	1943	111,713
1894	--	1944	113,521
1895	--	1945	114,018
1896	--	1946	115,928
1897	--	1947	116,278
1898	--	1948	118,298
1899	--	1949	122,492
1900	--	1950	124,304
1901	--	1951	127,534
1902	--	1952	131,993
1903	--	1953	134,053
1904	13,884	1954	135,175
1905	--	1955	138,831
1906	--	1956	145,900
1907	--	1957	149,705
1908	--	1958	153,968
1909	--	1959	158,561
1910	19,499	1960	163,730
1911	--	1961	167,291
1912	--	1962	173,420
1913	--	1963	176,516
1914	--	1964	179,599
1915	--	1965	187,305
1916	27,665	1966	191,567
1917	--	1967	194,650
1918	--	1968	193,690
1919	--	1969	189,956
1920	--	1970	186,743
1921	--	1971	--
1922	--	1972	181,035
1923	47,963	1973	173,775
1924	--	1974	166,247
1925	--	1975	159,058
1926	55,466	1976	153,584
1927	58,954	1977	--
1928	60,419	1978	139,432
1929	64,417		

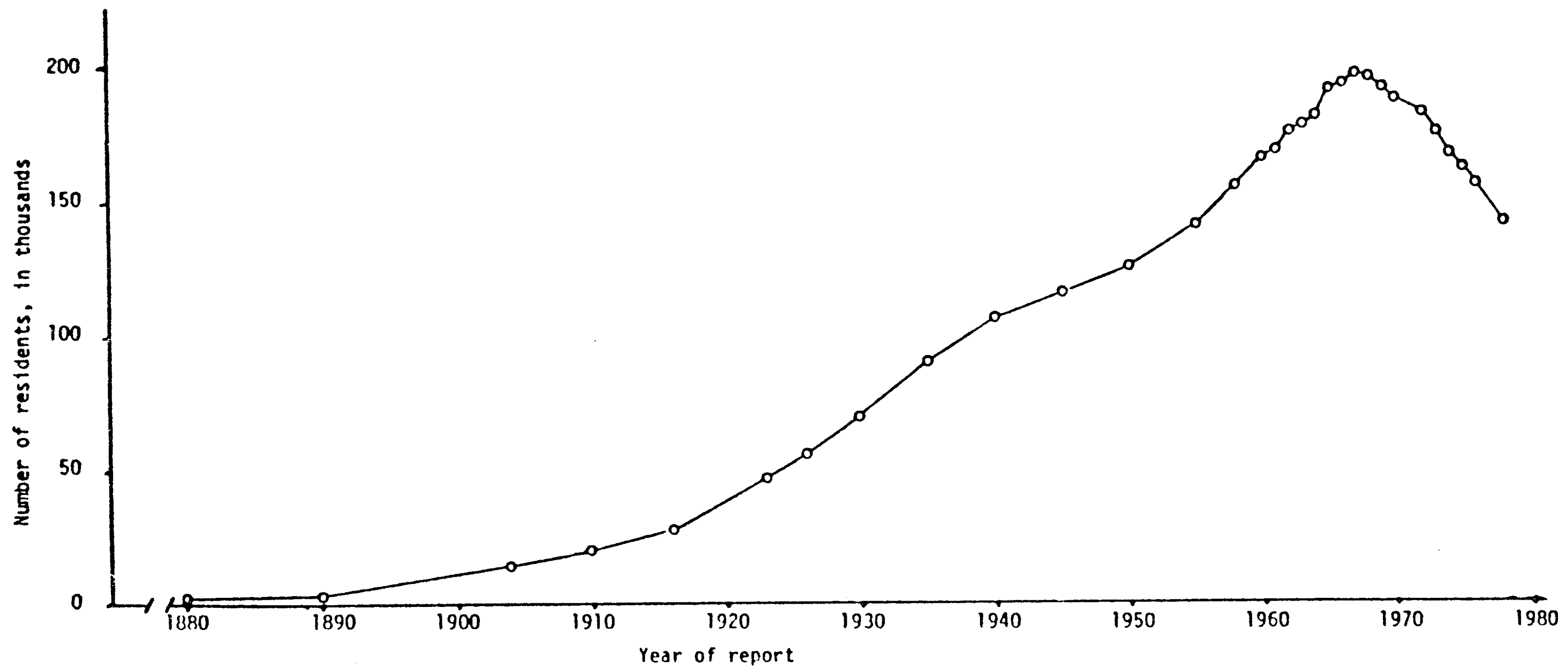

Figure 1. Total Populations of Mentally Retarded People in Public Institutions for the Period 1880 to 1978. (Lakin, 1979, p. 71)

Table 6

Total Number of Public Institutions for the Mentally Retarded in the U.S. 1880-1978

Year	Total Number	Year	Total Number
1880	10	1930	77
1881	--	1931	78
1882	--	1932	78
1883	--	1933	81
1884	--	1934	83
1885	--	1935	83
1886	--	1936	84
1887	--	1937	83
1888	--	1938	83
1889	--	1939	84
1890	20	1940	87
1891	--	1941	89
1892	--	1942	90
1893	--	1943	90
1894	--	1944	92
1895	--	1945	92
1896	--	1946	93
1897	--	1947	94
1898	--	1948	95
1899	--	1949	96
1900	--	1950	96
1901	--	1951	95
1902	--	1952	96
1903	--	1953	98
1904	28	1954	97
1905	--	1955	99
1906	--	1956	100
1907	--	1957	99
1908	--	1958	102
1909	--	1959	106
1910	35	1960	108
1911	--	1961	113
1912	--	1962	124
1913	--	1963	128
1914	--	1964	135
1915	--	1965	143
1916	40	1966	154
1917	--	1967	162
1918	--	1968	170
1919	--	1969	180
1920	--	1970	190
1921	--	1971	--
1922	--	1972	210
1923	66	1973	--
1924	--	1974	235
1925	--	1975	--
1926	77	1976	237
1927	77	1977	--
1928	77	1978	236
1929	77		

Table 7

Average Number of Residents per Public Institution for the Mentally Retarded
1880-1978

Year	Average	Year	Average
1880	243	1930	884
1881	--	1931	930
1882	--	1932	984
1883	--	1933	1063
1884	--	1934	1071
1885	--	1935	1095
1886	--	1936	1102
1887	--	1937	1136
1888	--	1938	1178
1889	--	1939	1213
1890	255	1940	1229
1891	--	1941	1231
1892	--	1942	1233
1893	--	1943	1241
1894	--	1944	1261
1895	--	1945	1239
1896	--	1946	1248
1897	--	1947	1237
1898	--	1948	1245
1899	--	1949	1275
1900	--	1950	1295
1901	--	1951	1342
1902	--	1952	1348
1903	--	1953	1348
1904	512	1954	1394
1905	--	1955	1402
1906	--	1956	1437
1907	--	1957	1492
1908	--	1958	1509
1909	--	1959	1495
1910	557	1960	1516
1911	--	1961	1480
1912	--	1962	1399
1913	--	1963	1379
1914	--	1964	1330
1915	--	1965	1309
1916	692	1966	1244
1917	--	1967	1202
1918	--	1968	1139
1919	--	1969	1055
1920	--	1970	982
1921	--	1971	--
1922	--	1972	862
1923	685	1973	--
1924	--	1974	707
1925	--	1975	--
1926	720	1976	648
1927	765	1977	--
1928	785	1978	591
1929	837		

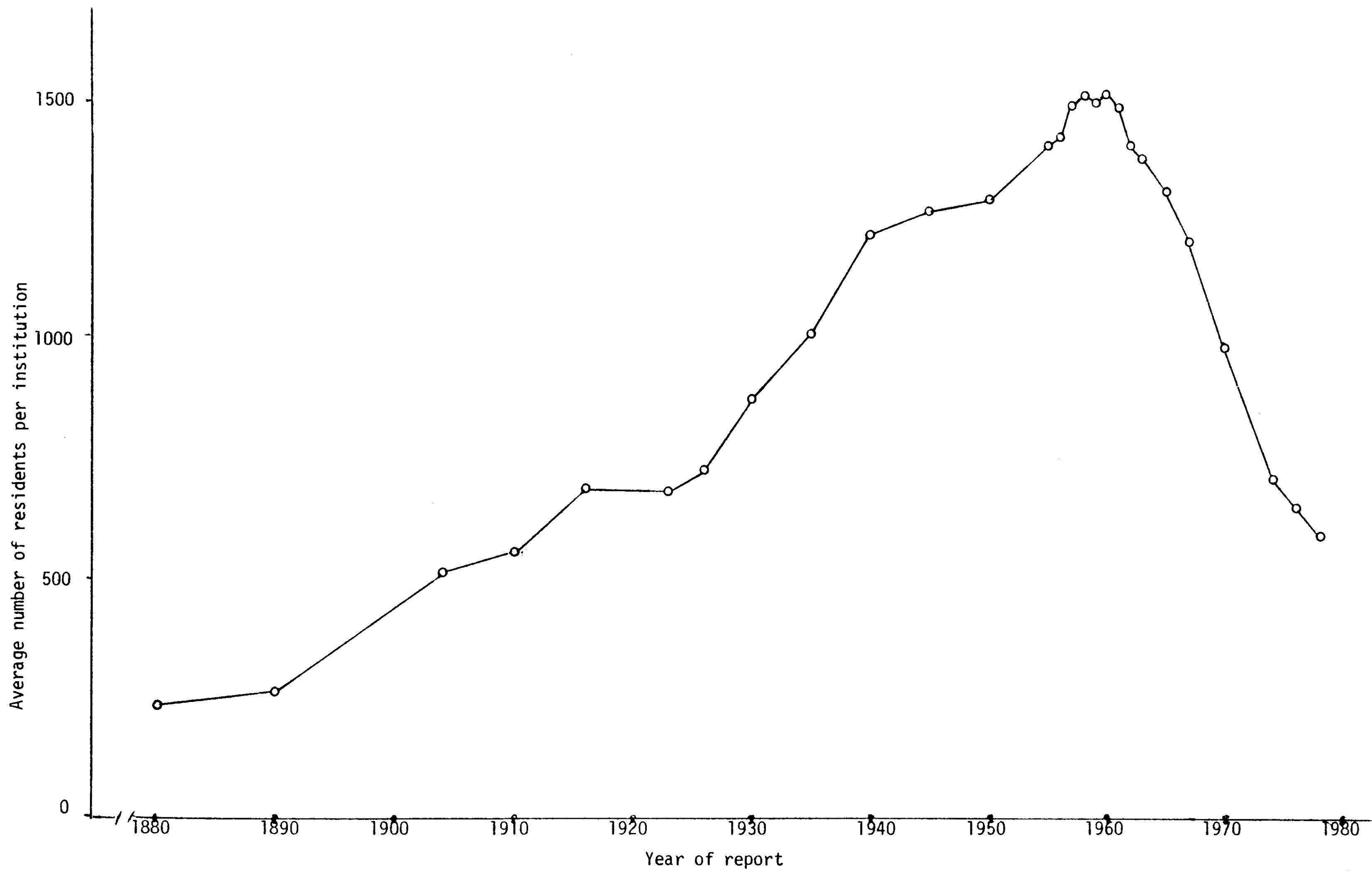

Figure 2

Average number of residents per public institution for the mentally retarded, 1880 to 1978.

to rise through 1967. As shown in Table 8, that number grew from 39.3 in 1923 to 81.1 in 1947 to a high of 99.0 in 1967. Following 1967 that ratio began dropping to the 1978 ratio of 64.9 residents of public institutions per 100,000 of the general population, the lowest point since 1932.

One of the more remarkable features of institutions for the feeble-minded prior to the 1950s was the stability in the characteristics of the residents. Not only did the institutions steadily grow during this period, but they did so apparently without major changes in the characteristics of the persons they admitted. In the 1950s, however, changes in the mental level of first admissions to these institutions can be noted. Slowly, higher percentages of more seriously handicapped persons can be seen among this group. Table 9 (see page 78) shows mental level of first admissions at ten-year intervals from 1922 through 1972 and again for 1976. The reader will note that for 1962 and prior years the old classification of "idiot," "imbecile" and "moron" is used. For 1962 data are provided according to both classification systems while for the years 1972 and 1976 they are recorded by the AAMD 1961 classification system which contained five levels of mental retardation: "profound," "severe," "moderate," "mild," and "borderline." (The borderline classification has not been included in Table 9, however.) As one can see from this table, the proportion of "severe" and "profound" first admissions among all mentally retarded first admissions has remained relatively stable (approximately 60 percent) for 1962, 1972 and 1976. The 1972 data are from Rosen and Callan (1972).

There has been a paucity of information on the characteristics of discharged residents of public institutions in recent years. In fact, the last year in which a survey of the mental level of discharges from public institutions for the mentally retarded was 1955. In the 1956 NIMH census of public institutions for mental defectives and epileptics, the following two reasons were given for not presenting tables on the characteristics of discharged patients:

> 1. Discharge from the books of an institution is used by different institutions in different ways. Some institutions discharge a large proportion of patients directly while others usually have a period of home leave, parole, convalescent leave, etc., prior to discharge. In many States discharge from home leave, etc., is administrative and does not require that the patient return to the institution. Therefore, since the definition of "discharge" is not consistent among States, the interpretation of discharge data is quite complex.

Table 8

Residents of Public Institutions for the Mentally Retarded per 100,000 of the General Population 1880-1978

Year	Residents/100,000	Year	Residents/100,000
1880	4.8	1930	56.4
1881	--	1931	60.0
1882	--	1932	61.6
1883	--	1933	67.2
1884	--	1934	69.2
1885	--	1935	70.6
1886	--	1936	71.7
1887	--	1937	72.8
1888	--	1938	74.9
1889	--	1939	75.5
1890	8.4	1940	76.7
1891	--	1941	77.8
1892	--	1942	78.4
1893	--	1943	78.9
1894	--	1944	81.3
1895	--	1945	81.2
1896	--	1946	81.6
1897	--	1947	80.4
1898	--	1948	80.4
1899	--	1949	81.8
1900	--	1950	81.6
1901	--	1951	82.3
1902	--	1952	82.4
1903	--	1953	82.4
1904	17.5	1954	82.9
1905	--	1955	83.7
1906	--	1956	85.1
1907	--	1957	86.9
1908	--	1958	88.0
1909	--	1959	89.1
1910	22.5	1960	91.9
1911	--	1961	92.6
1912	--	1962	94.4
1913	--	1963	94.6
1914	--	1964	94.9
1915	--	1965	97.6
1916	30.0	1966	98.8
1917	--	1967	99.0
1918	--	1968	97.5
1919	--	1969	94.6
1920	--	1970	92.1
1921	--	1971	--
1922	--	1972	86.9
1923	39.3	1973	83.2
1924	--	1974	82.8
1925	--	1975	74.7
1926	47.8	1976	71.5
1927	49.5	1977	--
1928	52.3	1978	64.9
1929	54.1		

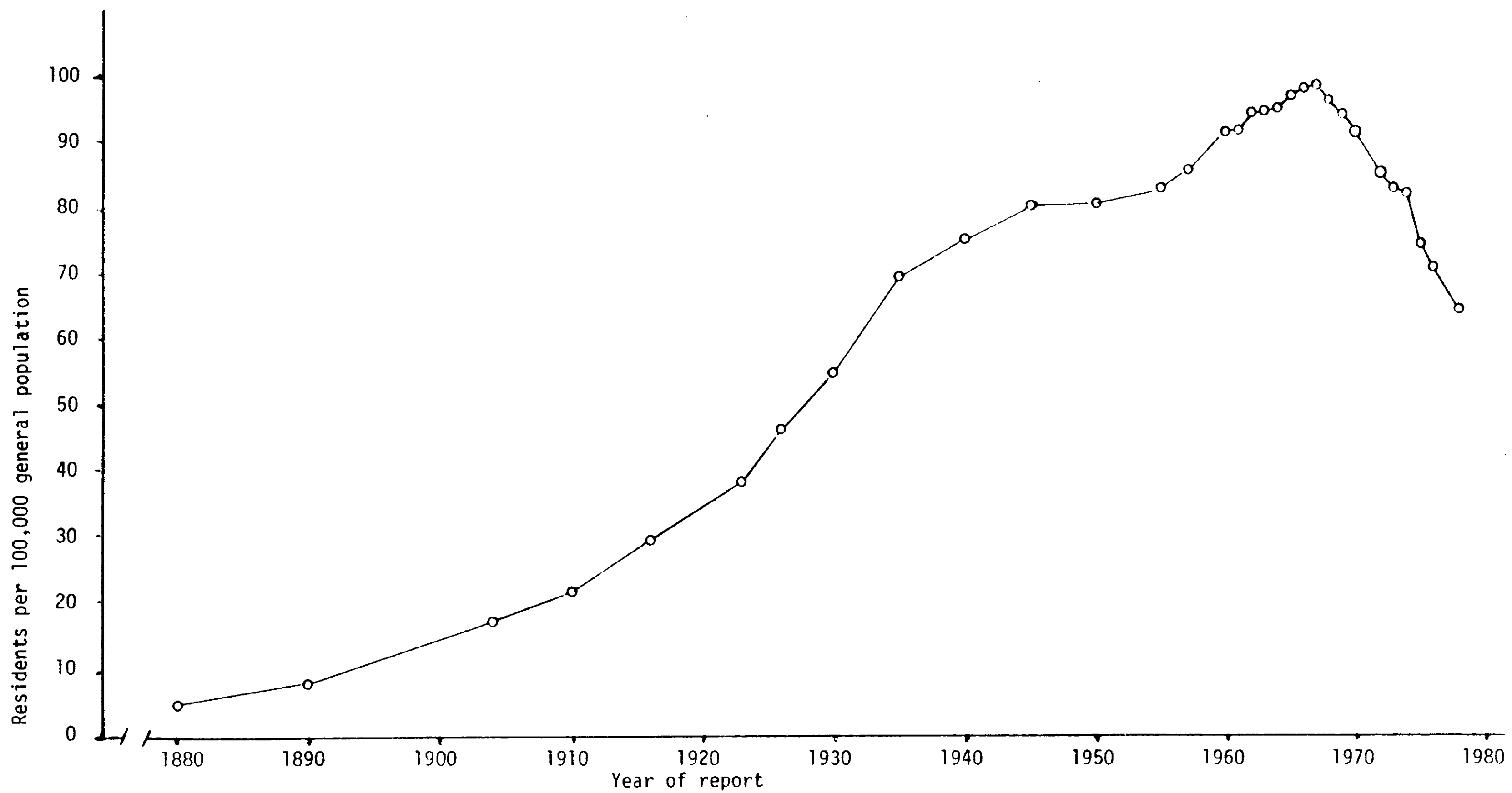

Figure 3

Number of residents of public institutions for the mentally retarded, per 100,000 of the general population, for the years 1880 to 1978.

Table 9

Level of Mental Defect of Classified Mentally Retarded First Admissions

Year	Idiot	Imbecile	Moron
1922	15.6	39.1	45.2
1932	15.1	33.7	50.8
1942	15.5	33.0	51.5
1952	23.0	38.1	38.9
1962[a]	29.1	39.3	31.5

Year	Profound	Severe	Moderate	Mild
1962[b]	34.4	23.2	21.6	20.7
1972	34.0	29.0	22.0	15.0
1976	31.3	29.9	21.3	17.5

[a] 1921 Classification

[b] 1961 Classification

Note: These figures are based on level of defect of first admissions for those that were reported, which in some years were as low as 70 percent of all first admissions.

> 2. The methods and standards for determination of condition on discharge are not uniform among the States. Thus, a valid interpretation of this statistic for single institutions or for comparisons between institutions or State systems cannot be made (NIMH, 1956, p. 9).

Still, given these reservations some of the discharge data collected before 1956 are of interest. Table 10 shows the percent of discharges by mental level at near five year intervals from 1922 through 1955. One clear problem with these data was a varying percentage of unclassified feeble-minded persons each year. Although data are not available on discharge by level of feeble-mindedness from 1924-1932, for 1934, or for years following 1955, a trend clearly developed from 1922-1942 towards higher percentages of mildly feeble-minded (morons) and lower percentages of more seriously handicapped (idiots and imbeciles) persons being discharged. Following 1947, however, this trend began to reverse itself with relative rates of discharge among more seriously mentally handicapped institutionalized persons increasing markedly in the years following the Second World War.

This trend, of course, was both affected by and had an effect on the nature of the populations remaining in public institutions. Clearly, the trend created a major problem which has a contemporary theme. Pense noted the effect of this trend in 1946, commenting that in New York State:

> There has been a decrease in the proportion of patients with higher intellectual endowment in the institutional population.... Over a ten-year period the percentage of morons was reduced from 53.9 percent in 1934, to 40.7 percent in 1943, with an equalizing increase of idiots and imbeciles, most of whom require...infirmary care. For obvious reasons efforts to adjust the feeble-minded to the community have been more successful with the moron than with the lower mentality patients. This tends to increase the institutional residue of low grade cases (Pense, 1946, p. 455).

Pense's comments are in a sense a prologue to many of the problems that would be encountered from the late 1960s until the present when large scale efforts were made to place mentally retarded persons in the community when considered feasible. But it is important to note that a more liberal policy toward releasing mentally defective persons from the institution was slowly evolving prior to World War II. It was far from a commitment to normalization, and probably was greatly encouraged by the pressures of overcrowding within existing institutions, but, as will be seen in Table 11, the ratio of discharges to

Table 10

Percentage of Total Discharges by Reported Levels of "Mental Defect" 1922-1955

Year	Idiot	Imbecile	Moron
1922	8.8	34.7	56.5
1932	6.6	26.6	66.8
1937	3.5	18.0	77.3
1942	2.7	18.9	78.3
1947	4.0	20.9	75.1
1952	4.2	21.3	74.4
1955	6.0	25.6	68.5

Table 11

Number of Discharges[a] per 100 First Admissions

Year	Percentage
1904	24.9
1910	26.1
1922	39.6
1927	45.5
1937	49.7
1942	57.5
1947	61.7
1952	57.6
1957	43.7
1962	42.9
1967	85.5
1970	122.0
1978	299.0

[a] Net releases after 1960

first admissions during this period grew considerably and has continued to grow until the present; and as has been seen in Table 10, by the mid-1930s over 75 percent of these discharges were of the mildly retarded persons while fewer than one-half the first admissions came from this group. The effect of this, of course, was in Pense's words "to increase the institutional residue of low grade cases." Still, despite an institutional population that was growing progressively more seriously impaired, institutions since the beginning of this century generally have been increasing their rate of discharge more rapidly than has grown the rate of first admissions. Since the mid-sixties this relative rate of change has been enormous.

In looking at Table 11 the reader will note that the number of discharges per one hundred first admissions shows one period (1947-1867) when the trend toward a progressively higher ratio of discharges to first admissions was broken. The cause of this change was to a great extent the large demographic shift in America's population during that period. As Conley (1973) has pointed out and is evident from the NIMH institutional censuses, most persons admitted to institutions for the mentally retarded are children (median age 12). In the post-war years there was a tremendous growth in America's childhood population. This was, then, a period in which America had an unprecedented number of persons in the age group most at risk of admission to institutions for the mentally retarded. What in effect occurred during this period was a rapid growth in first admissions while discharges remained relatively stable. In 1952, for example, the first year that the decrease in the ratio of discharges to first admissions is visible, 63 percent of all admissions were children under 15, while only 13 percent of all discharges fell in that age bracket. As the baby boom continued, more and more children fell into the at-risk age groups, and for that period, first admissions grew more rapidly than discharges. By the mid-sixties the trend toward higher ratios for discharges had been reestablished.

In explaining the reason for no longer collecting data on "condition of discharges," the NIMH report of 1956 mentioned that "methods and standards... [were] not uniform among the States." This, of course, is not a limitation solely of the discharge data, but a problem which causes limitations with nearly all the demographic studies reviewed in this paper. This is a major, although not the only limitation of the data reported in a review such as this. Another problem revolves around the presentation of trends among populations

of the institutions which have been consolidated on the national level. This consolidation has, of course, masked wide variability among states and regions. As an example, the rates of hospitalization (residents per 100,000 of general population) for public institutions in 1938 varied from 4.3 in West Virginia to 159.8 in Delaware. The national rate for that year was 74.9. In 1941 the national average was 77.8 with the range from 8.2 in West Virginia and 14.2 in New Mexico to 162.1 in Delaware and 160.0 in Massachusetts. Several of the Bureau of the Census reports were quick to point out that such differences reflected more on social and economic realities in the various states than upon any differences in intellectual potential of their residents. Those interested in comparisons among the various states must, however, be referred to the individual studies mentioned in this review.

In this review the resident populations reported refer only to patients in institutions prior to 1952 and to the average daily residents thereafter. There were, however, a number of alternative residential placements which became increasingly utilized in the years covered by this review. It is virtually impossible to assess the degree to which these alternatives were provided to the inmates of public institutions based on the data provided. One reason revolves around administrative arrangements. For example, one type of provision developed during this period, but which is not reflected in the data collected, is "colony care." According to the 1941 report: "in many institutions of the country a large proportion of the number reported in the institution did not reside in the institution proper, but in employment colonies of the institution" (Bureau of the Census, 1941, p. 256). Just how many persons resided in these colonies is not known since this information was buried in the totals of inmates in the institution. Often, however, the designation of those in colony care as being in the institution is misleading if the reality of colony care was in any way reflected in the description provided in the 1941 Bureau of the Census report. According to the report:

> Colony care provides training in occupations more likely to prove economically profitable than the activities taught in institutional occupational therapy. There are farm colonies in which the training given may eventually lead toward employment of the boys as helpers on neighborhood farms. There are industrial colonies for boys as well as girls. These are usually maintained in a city not far from the institution where there are mills or factories to provide employment.... Colony care, by developing responsibility in the individual for the job that he performs,

> establishes his confidence in his ability to do something worthwhile. He has an opportunity to prove to himself that he is able to get along quite well outside the institution, and to prove to the institutional authorities that he is ready to be placed on parole (Ibid., pp. 256-257).

So while among some institutions extensive programs existed to prepare inmates for parole and eventual discharge, in other institutions placement in similar programs not administered by the public institution may have been preceded by either "parole" or "discharge" status. In other words, the total number of persons in the institution reflects administrative status, but not necessarily residential status. The problem is still with us.

A number of categories of placement status other than in institution were distinguished in the annual census reports beginning in 1923. One of these was family care or foster care. This innovation of the 1930s was apparently first discussed in the literature in 1935 by Vaux as he outlined New Jersey's family care program. The first nation-wide data on the extent to which foster care was used for institution residents were published in the Bureau of the Census report of 1937. In that year there were 802 such placements. In 1945 there were 756 foster placements. Only nine institutions reported any such placements from 1937-1945 and New York and Indiana accounted for the vast majority of these. Twenty years later, however, nearly 6,700 foster placements were reported by public institutions. When data were last collected on the use of family care by public institutions in 1966, it was clear that this was a rapidly growing option for the community placement of persons committed to public institutions. (The reader must again bear in mind that the numbers reported do not refer to the total of all mentally retarded persons in family care, but only the number of persons on the books of the public institutions who had been placed in family care by the institution. Clearly in the post-war era the growth of social service agencies meant that many more mentally retarded persons could be placed in foster care without first being admitted to public institutions.)

Although the period from 1923 to 1946 is most notable for the steady growth in both the number and size of the institutions created to care for mental defectives, it was also a period during which the percentage of inmates in "community placements" kept pace with the rate of institutionalization. Beginning in 1922 patient movement data were kept on inmates on parole. In the

1923 report, "parole" was defined as follows:

> A parole is a patient who is temporarily absent from an institution but is still carried on its books. The term is frequently used to indicate a trial leave of absence, but it may signify temporary absence on visit or for other purposes (Bureau of the Census, 1923, pp. 13-14).

These data, then, were collected beginning from the very years in which strong evidence was first presented by Fernald (1919; 1924), Anderson (1922) and Wallin (1924) that the mentally defective, even those who had been institutionalized, were capable of living "moral" lives in a normal community. These data can be seen as an indicator of the degree to which this discovery was acted upon.

For the purposes of the 1923 study, an inmate who had been on parole for more than one year was counted as a discharge. This distinction, which was not made in the later censuses of the period, had the effect of making the number of parolees in 1923 relatively lower than it would have been under the definition used in subsequent studies. In the studies beginning in 1926, the category "on parole" was broadened to "on parole or otherwise absent" and further broken down in 1937 into the categories "in family care" or "in other extramural care." Family care referred to an arrangement where "patients, most recovered sufficiently to be paroled or discharges, [were]...placed in the community in private families other than their own [emphasis in text] with remuneration to the family by the hospital or institution" (Bureau of the Census, 1945, p. 206), "...with the object of giving the patient whatever benefit [that might be] derived from the intimate and closer contacts and relationships possible in a family unit" (Bureau of the Census, 1939, p. 250). The category "in other extramural care" referred to patients in extramural care other than family care "...in which the ability of the patient to adjust to normal community life is tested" (Bureau of the Census, 1945, p. 207). "Other extramural care" then referred to paroles to the inmate's natural family and other trial release as well as community placement not directly under the jurisdiction of the various public institutions. In 1922 there were 3,758 inmates on parole. By the beginning of World War II that number had jumped to 16,149 and by 1947 the number of residents in family care and other extramural care was 18,097. While considerable growth is evident in the number of persons in extramural care during this period, it is worthwhile to note the parolees as a percentage of

the total number of wards of the institutions remained virtually unchanged from 1927-1947. In the 1950s this percentage decreased somewhat, before again rising in the sixties (see Table 12). However, it must be recognized that the number of persons remaining on the books of the institution while in extramural care is highly related to the alternatives of extramural care, legal authority, and the administrative policies which determine the conditions under which one is completely discharged. Again it must be emphasized that the Bureau of the Census and NIMH reports were primarily bookkeeping in nature and made no attempt to measure the type of care provided those who were discharged from the institution. None of the surveys of institutions since 1965 have requested an accounting of persons carried "on the books" of the institution, i.e., for whom the institution retains some responsibility, but who are not actually residing in the institution. Scheerenberger's 1976 report, however, did indicate that 36 percent of the responding institutions could readmit "temporarily discharged" residents without formal readmission hearings, indicating that they did retain a certain degree of responsibility extending beyond the time the person was placed in an alternative residential facility (Scheerenberger, 1976, p. 48).

While clearly some of the early colony care and family care arrangements were motivated by a desire to provide inmates with more normalized residential arrangements, the 1945 report suggests that another factor was involved:

> Colony care was adopted because it went a long way toward solving...problems...urgent to many institution superintendents. At a time when no funds were available from State appropriations [these were the depression years] for the provision of additional bed capacity, it released a certain number of institution beds to which defective patients in the community in acute need of institutionalization might be admitted (Bureau of the Census, 1945, p. 257).

Clearly, overcrowding was a growing problem in institutions during this period. With the depression cutting into the revenues available for public institutions and a generally low priority of institutions for mental defectives in the eyes of the general public, institutions went from operating at normal capacity in 1932 to over 14 percent in excess of their normal capacity by 1948. The last estimate of overcrowding among institutions for the mentally defective and epileptic were reported in 1949. At that time these data were discontinued for the following two reasons:

> One, many institutions for mental defectives and epileptics maintain long waiting lists and tend to admit patients as space

> becomes available. Secondly, the standards upon which rated capacity is measured vary so widely both in time and among States as to make comparisons misleading (NIMH, 1952, p. 10).

Scheerenberger soundly supported the second of these reasons when he noted that a comparison of the same 135 institutions "between 1964 and 1976 revealed a substantial decrease in total rated bed capacity from 180,113 to 132,717, a 26.3 percent reduction" (Scheerenberger, 1976, p. 4). Table 13 shows capacity figures for reporting institutions from 1932 through 1949 and for 1974 and 1976.

The number of inmates dying while institutionalized was first reported for the year 1903. This information was thereafter collected in every institutional census until 1971. From 1972 through 1977, data on institutional deaths were not collected in any of the national surveys reviewed in this volume. This information, however, was collected in 1978 as part of the Developmental Disabilities Project on Residential Services (Krantz et al., 1978). Table 14 presents the sum of the total available since 1903. As can be seen, there has been a good deal of stability in the total numbers of deaths reported during this period. What makes this stability most remarkable is the tremendous rise in the total population of public institutions during this same period. The death rate per 1,000 average patients best points out the substantial relative decrease in death rates over this same period. Making this trend even more remarkable is the fact that over these years the resident population of public institutions increasingly has been made up of more severely mentally handicapped persons (Bureau of the Census, 1933; Pense, 1946; Scheerenberger, 1974; 1976).

Data on discharges from public institutions for the mentally retarded have been collected since 1904. These data have, however, been reported in two different ways. Prior to 1960 discharges were reported as the number of persons who were formally released from either the institution or from parole. Theoretically, this number should have equaled:

$$\text{Residents at Beginning of the Year} + \text{Admissions (Excluding Transfers)} - \text{Deaths in Institution} - \text{Residents at End of the Year} = \text{Discharges or Live Releases}$$

Unfortunately it never did, although the number was usually relatively close. One resolution of this problem was to begin computing net releases according to the above formula, rather than asking the individual institutions to provide their count of the number of residents actually discharged in a given year.

Table 12

Number of Persons "on Books" of Public Institutions for the Mentally Retarded Cared for Outside the Institution (excluding "Colony Care") 1922-1965

Year	Total Number	Number Outside per 100 Inmates
1922[a]	3,758	7.8
1927	8,077	13.7
1932	10,827	14.1
1937	14,042	14.9
1942	17,056	15.4
1947	17,986	16.3
1952	17,911	13.6
1957	19,988	13.4
1962	20,863	12.0
1965	24,797	13.2

[a] For 1922 those who had been on parole for more than one year were recorded as discharged.

Table 13

Average Resident Population and Normal (Rated) Capacity of Reporting Institutions for Reported Years

Year	Average Population	Normal (rated) Capacity	% Excess Capacity
1977			
1976	165,710	153,584	- 7.9
1974	148,160	141,522	- 4.7
1964[a]	180,133	192,493	- 6.9
1949	124,944	110,317	13.3
1948	121,149	105,896	14.4
1947	118,047	104,427	13.0
1946	113,979	100,244	13.7
1945	113,482	105,586	7.5
1944	112,641	104,765	7.5
1943	107,948	100,169	7.8
1942	112,518	105,012	7.1
1941	104,041	99,749	4.3
1940	99,086	92,999	6.5
1939	97,680	92,424	5.7
1938	99,393	93,388	6.4
1937	96,699	92,564	4.5
1936	93,679	89,290	4.9
1935	92,190	89,535	5.3
1934	89,229	84,440	5.7
1933	85,343	83,579	2.1
1932	80,939	80,945	0

[a] 1964 data from Scheerenberger (1965). Population figures are not an average, but the actual population on November 1, 1964.

Table 14

Deaths in Public Institutions
1904-1978

Year	Deaths	Rate per 1,000 Average Residents
1903	574	41.3
1910	895	45.9
1922	1762	40.0
1926	2228	40.2
1930	2293	33.7
1935	2679	29.8
1940	2338	21.8
1950	2832	24.8
1955	2761	22.2
1960	2698	19.4
1965	3133	19.1
1970	3583	19.0
1975	3496	18.7
1978	2154	15.4

Figure 4

Deaths, expressed here as a percent of the residential population during each year, in public institutions for the mentally retarded in the years from 1915 to 1978.

This was done with the "Mental Health Statistics, Current Reports" of NIMH beginning in 1960, while the Patients in Mental Institutions continued to report actual discharges. Table 15 presents discharge data (net releases after 1960). Also provided for selected years are data on the percent of total discharges released directly from the institution, as opposed to those released from parole, family care or other alternative arrangements, and the ratio of discharges per 100 first admissions. This latter ratio is highly sensitive to the first two of the three purposes of deinstitutionalization outlined in a Statement of the National Association of Superintendents of the Residential Facilities for the Mentally Retarded (1974) in which it was stated:

> Deinstitutionalization encompasses three interrelated purposes: (1) prevention of admission... (2) return to the community of all residents who have been prepared through programs of rehabilitation ...and (3) establishment and maintenance of a responsive residential environment (pp. 4-5, emphasis provided).

Of course, this massive effort to deinstitutionalize residents of public facilities has led to the discharge of many persons who a decade ago would not likely have been discharged. A result of this effort has been the eventual readmission of many persons for whom community placement has been deemed unsuccessful. Data on readmissions have been collected since 1922. As can be seen in Table 16, readmissions have been increasing rapidly in recent years as more formerly institutionalized persons are placed in the community. This fact, along with the rapid drop in first admissions reported in the most recent survey (Krantz et al., 1978) has created a much higher proportion of readmissions among the total admissions of public facilities. This can be seen in Table 16.

Staffing and Costs of Institutional Care

Table 17 shows the ratios of inmates to staff in 1915, 1922, from 1922 through 1970 and in 1974, 1976, and 1977. With the exception of the darkest years of the depression when public facilities were hard pressed for funds, and the last two years of World War II when the country suffered a severe manpower shortage, the ratio of inmates to staff remained between 6.0 and 6.9 percent through 1947. This consistency in the staffing ratio again reflects the stability of the institution model for caring for mental defectives during this period. The fact that inmate-staff ratios went basically unchanged throughout this span of over thirty years is made even more remarkable when one compares

Table 15

Total Discharges from Public Institutions

Year	Number	% from Institution	Discharges per 100 First Admissions
1904	649	--	24.9
1910	1009	--	26.1
1922	2764	--	39.6
1927	4165	--	45.5
1930	3671	--	--
1935	4911	--	45.6
1940	5689	27.1	50.3
1945	6487	23.5	62.0
1950	6362	24.3	58.0
1955	5485	31.1	45.4
1960	6451	27.4	49.5
1961	7979	--	57.7
1962	7764	--	60.3
1963	8156	--	61.1
1964	9292	--	69.2
1965	7993	26.7	53.3
1966	9268	--	70.5
1967	11665	--	85.5
1968	11675	--	92.7
1969	14701	--	118
1970	14702	--	122
1978	15412	--	299

Table 16

Readmissions to Public Institutions for the Mentally Retarded

Year	Readmits	Readmissions/100 First Admissions
1922	446	6.0
1926	776	9.4
1930	820	8.1
1935	765	7.4
1940	961	9.9
1945	904	8.8
1950	1,273	11.6
1955	1,004	8.3
1960	1,161	8.9
1961	1,234	9.5
1962	1,253	10.7
1963	1,508	11.4
1964	1,587	14.6
1965	2,359	15.0
1966	2,012	15.5
1967	2,070	15.2
1968	2,096	16.6
1969	2,910	21.6
1970	NA	24.1
1974	5,290	38.2[a]
1978	--	102.9

[a] Based on 70 percent of public institutions.

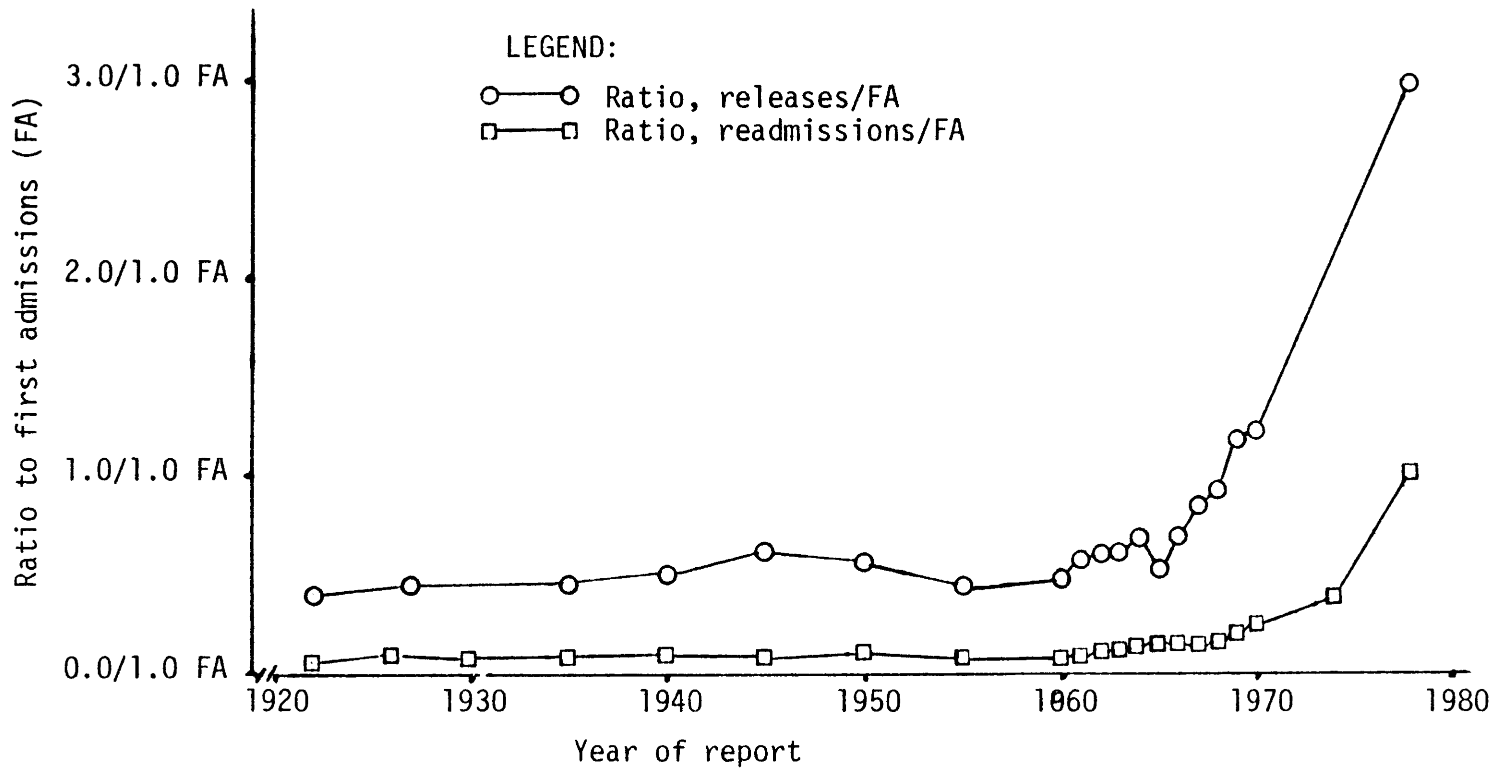

Figure 5

Ratio of discharges to first admissions (circles), and ratio of readmissions to first admissions (squares), for public institutions for the mentally retarded in the years 1922 to 1978; the rates per first admissions given in Tables 15 and 16 have been converted here from rate per 100 to a direct ratio.

Table 17

Ratio of Patients to Staff; Public Institutions for the Mentally Retarded

Year	Ratio
1915	6.0
1922	6.6
1927	6.4
1928	6.3
1929	7.0
1930	7.4
1931	6.5
1932	6.6
1933	6.9
1934	6.9
1935	6.6
1936	6.4
1937	6.2
1938	6.2
1939	6.1
1940	6.2
1941	6.1
1942	6.7
1943	6.9
1944	7.1
1945	7.0
1946	6.4
1947	6.0
1948	5.6
1949	5.1
1950	4.9
1951	4.7
1952	4.5
1953	4.3
1954	4.0
1955	3.9
1956	3.7
1957	3.5
1958	3.3
1959	3.2
1960	3.0
1961	2.9
1962	2.7
1963	2.6
1964	2.4
1965	2.4
1966	2.2
1967	2.0
1968	1.9
1969	1.8
1970	1.6
1971	--
1972	--
1973	--
1974	1.7[a]
1975	--
1976	1.6[a]
1977	1.4[b]
1978	--

[a] Based on approximately 70 percent of all public institutions

[b] Facilities reporting data for the computation of this ratio included 20 mental hospitals not included in previous surveys.

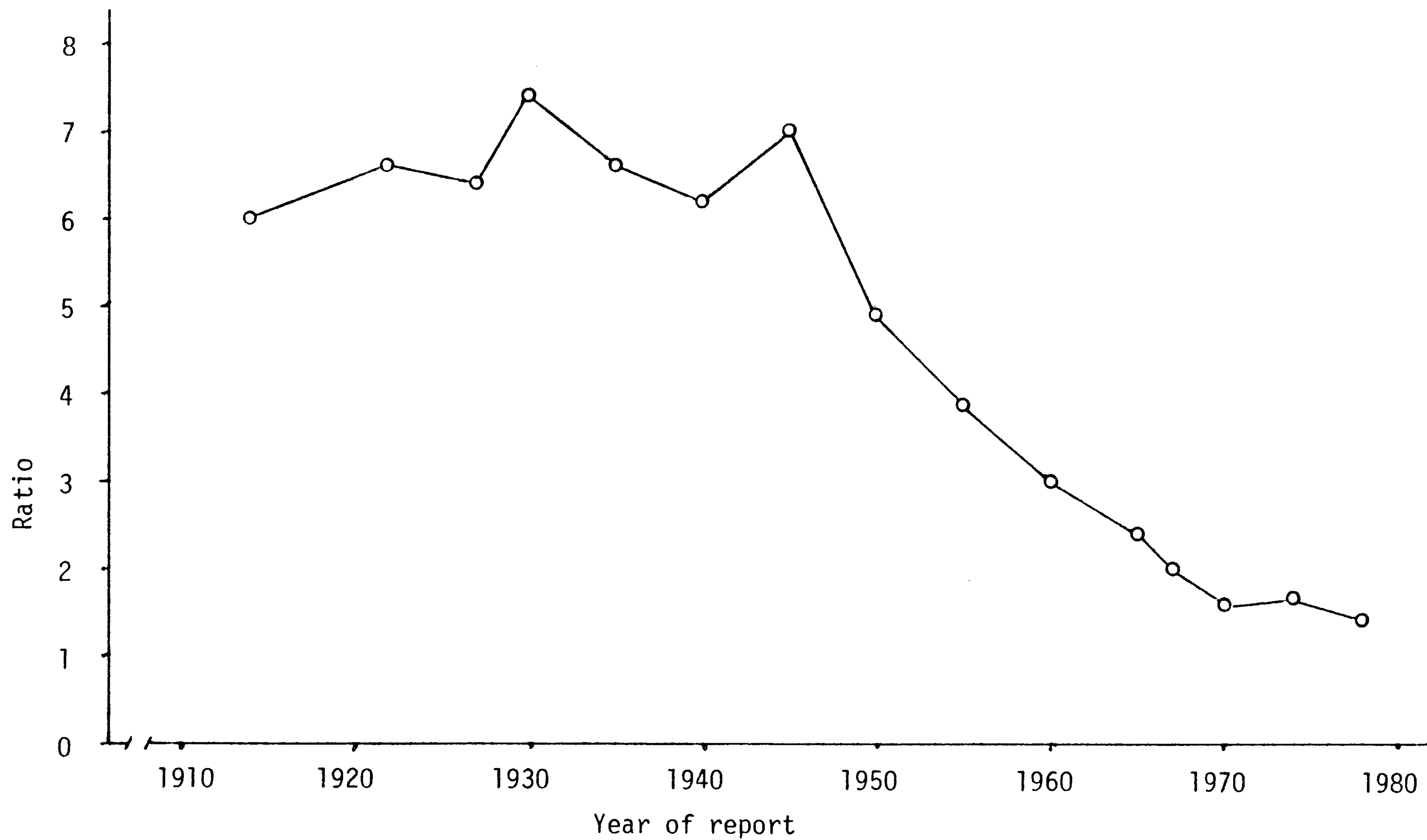

Figure 6

Ratio of patients to staff (number of patients per one staff member), public institutions for the mentally retarded, for the years 1915 to 1978.

it with the sharp drop in the ratio following the Second World War. By 1970 the inmate-staff ratio had fallen to 1.6, one-quarter of the 1946 ratio, and appears to have stabilized at about that ratio through 1977.

Closely related to the patient-staff ratio is the annual per-resident expenditure among institutions for the mentally retarded. Data have been available on per capita expenditures for residents in public institutions for the mentally retarded since the Statistical Directory of State Institutions for the Defective, Dependent and Delinquent Classes (1919) published administrative data for 1915. In that year the mean cost of maintaining a person for a year in an institution for the feeble-minded was $182.52. Wide variations were found, however, in the expenditures among individual states. For example, Colorado's expenditures in 1915 ($361.08 per inmate) were more than three times those of Alabama ($119.28 per inmate). By 1945 the average expenditure per patient for one year had risen only moderately to an equivalent of 218 1915 dollars or $386.11 actual dollars in 1945. Again wide variation was evident among states, with Michigan's annual expenditure ($579.73 per resident) nearly four times that of Oklahoma ($148.54). Since the end of World War II, however, the annual per capita expenditure for institutions for the mentally retarded has risen dramatically. In 1978 it cost on the average over $18,000 per year ($50.10 per day) to maintain one person in a public institution for the mentally retarded (Krantz et al., 1978). The reported per diem costs ranged from Alaska's $116.05 to Mississippi's $21.20. A total of three states reported daily costs of more than $70.00 while six reported costs below $30.00.

Table 18 presents both annual per capita costs and those costs in 1967 dollars for all years since 1915 for which these data are available. It is clear from this table that both actual costs and 1967 real dollar costs rose steadily in the first half of this century and have risen dramatically in the second half.

Staff costs are the greatest operating expense for public institutions. Scheerenberger (1976) reported that 80 percent of the budgets of the 231 public institutions he surveyed were devoted to salaries and wages. But the steady decrease in the number of staff members per resident is not sufficient to explain the rising cost of institutional care for the mentally retarded in the United States. In Table 19 the average cost per resident per year in 1967 dollars has been multiplied by a factor of the number of residents per staff member. If,

Table 18

Annual per Capita Costs for Residents of Public Institutions for the Mentally Retarded 1915-1978

Year	Cost	Cost (1967=$1.00)
1915	182.52	600.39
1922	309.81	606.28
1927	304.02	584.65
1928	300.67	586.10
1929	281.10	547.95
1930	265.05	530.10
1931	287.85	631.25
1932	262.57	641.98
1933	238.24	641.02
1934	236.87	590.70
1935	252.22	613.67
1936	259.06	624.24
1937	278.59	647.88
1938	283.43	671.64
1939	288.05	692.43
1940	291.13	693.17
1941	287.98	653.02
1942	315.29	646.09
1943	347.48	670.81
1944	365.20	692.98
1945	386.11	716.35
1946	433.79	741.52
1947	527.91	789.10
1948	631.38	875.92
1949	697.72	977.51
1950	745.60	1034.15
1951	807.11	1037.14
1952	1112.50	1399.52
1953	1186.83	1481.16
1954	1204.07	1495.45
1955	1285.50	1603.02
1956	1394.34	1713.23
1957	1507.13	1787.46
1958	1596.47	1843.92
1959	1746.92	2000.22
1960	1867.70	2104.90
1961	1916.12	2138.39
1962	2033.96	2245.49
1963	2130.38	2324.24
1964	2208.19	2376.01
1965	2361.08	2498.02
1966	2619.81	2695.78
1967	2965.33	2695.33
1968	3471.99	3332.04
1969	3995.58	3638.96
1970	4634.85	3985.25
1971	--	--
1972	--	--
1973	--	--
1974	9937.50	6728.17
1975	--	--
1976	13052.30	7655.31
1977	--	--
1978	18286.65	9377.77

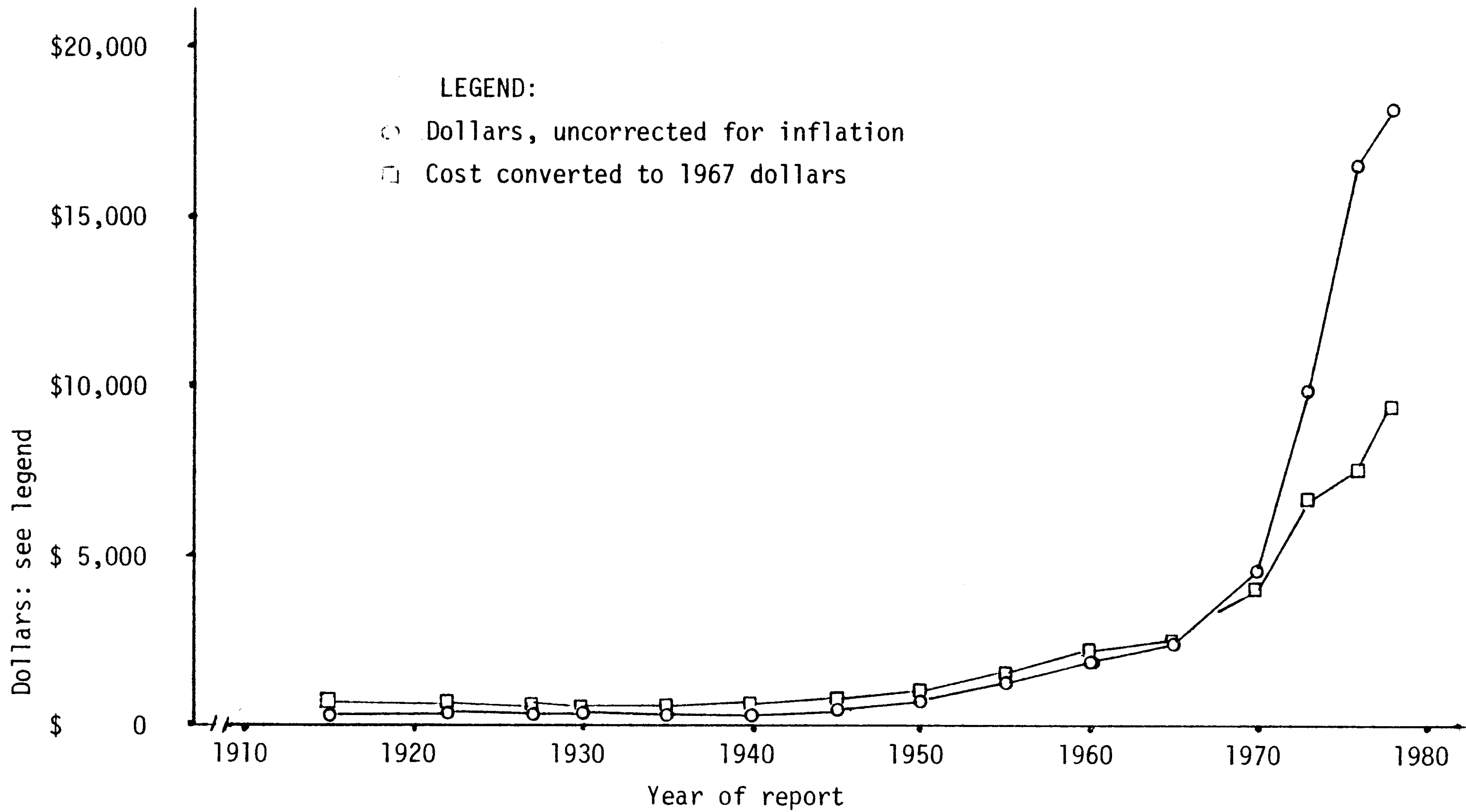

Figure 7

Annual cost per resident of care in public institutions for the mentally retarded for the years 1915 to 1978.

having controlled for inflation by placing maintenance expenditures in 1967 dollars, resident/staff ratios were responsible for increases in the cost of institutional care, then the "real costs" multiplied by the resident/staff factor should all be equal. As can be seen clearly, this is not the case. The real dollar cost of institutional care is not affected solely by the number of staff members for a given number of residents. While from 1928 to 1968 this cost times resident/staff figure grew only 71 percent, or on the average less than 2 percent a year, from 1968 to 1978 this number grew 122 percent or 12 percent a year. Since 80 percent of annual maintenance costs were for salaries in 1976 (versus 69% in 1956), clearly a staffing factor is involved in these rising costs. That staffing factor, however, must involve a substantial variation in the real dollar cost of the staff in recent years versus those of past decades. This variability, of course, is strongly influenced by the type of staff employed and the market value which institutions must pay for their services.

Earlier in this review it was mentioned that over the years the resident population of public institutions has been changing in the direction of greater proportions of severely handicapped residents. This fact, as well as the social criticism and related legislature and judicial actions, has compelled (in many cases allowed) new staffing patterns in public institutions for the mentally retarded. These personnel changes have been in the direction of more highly specialized and, therefore, more expensive work forces. Table 20 shows the extent of these changes in two occupational groupings: medical specialists (medical doctors, dentists and registered nurses) and therapists (physical, occupational, vocational and recreational) over a twenty-year period. As can be seen, there has been substantial change in the proportion of the total institutional staff made up of persons trained in these specialized fields.

Similar trends toward a more specialized labor force in public institutions can be seen in areas such as social work, special education and psychology, while the number of attendants and licensed nurses appears to have remained relatively stable over the past few years (Scheerenberger, 1974; 1976).

Private Institutions

In each of the censuses of mental defectives in institutions conducted by the Bureau of the Census, with the exception of those years from 1926-1932 when the census was specifically limited to state institutions, an attempt was made

Table 19

Effect of Lowered Resident/Staff Ratio on Institutional Costs

Year	Cost ($1967)	Resident/Staff	Cost X Resident/Staff
1928	586.10	6.3	3692.43
1938	671.64	6.2	4164.17
1948	875.72	5.6	4904.03
1958	1843.92	3.3	6084.94
1968	3332.04	1.9	6330.88
1978	9377.77	1.6[a]	15004.43

[a] 1976 ratio reported by Scheerenberger (1976)

Table 20

Proportion of Total Staff of Persons Trained in Two Specialized Fields

Year	Medical Specialists	Therapists
1956	2.6% of Total Staff	1.3% of Total Staff
1966	5.0% of Total Staff	1.7% of Total Staff
1976	6.3% of Total Staff	3.9% of Total Staff

to enumerate mental defectives in private institutions for that "class." This effort for the years prior to the initiation of the annual studies (1926) has been described briefly in the first section of this review.

The procedure developed for generating a complete list of all such facilities in order to conduct an adequate survey was reviewed in the 1947 report by the National Institute of Mental Health which continued these special censuses beginning in that year. That report stated that the locations for the private facilities were obtained through lists provided by state licensing agencies (NIMH, 1947, p. 113). This procedure was adopted by NIMH in continuing these surveys. The report went on, however, to caution that "in those states where there [was] no State licensing of private institutions, it is possible that schedules were not sent to all institutions or schools" (NIMH, 1947, p. 113).

From 1890 through 1923 the Bureau of the Census was successful in obtaining returns of its abbreviated schedule from all known private institutions. After discontinuing the collection of these data from private institutions for ten years, the survey was reinstituted in 1933. Returns from 1933 were nearly complete (93%), but unfortunately the survey from then on, until it was passed to the National Institute of Mental Health, suffered a steady decline in the rate of return, never reaching 80 percent after 1937.

If the return rate was discouraging for the Bureau of the Census survey personnel, they could have taken heart from the rate of return subsequent to the passage of responsibility to the National Institute of Mental Health. While there was a brief honeymoon period in which NIMH returns increased over those which had been obtained by the Bureau of the Census (increases in returns occurred the first three years of the NIMH survey to a high of 86% in 1949), the rate of return soon began to decrease. By 1961 the return rate had fallen below 50 percent and in 1965 publication was discontinued, although mimeographed data were made available on request.

In 1969 a survey of the Master Facility Inventory was conducted by the National Center for Health Statistics. In this survey of all inpatient health facilities in the U.S., 708 facilities were located which functioned as residential facilities for the mentally retarded. In these facilities a reported 33,002 mentally retarded persons resided. To some degree, the survey of the Master Facility Inventory appears to discredit further the data collected by NIMH through 1966, already of very little use because of low rates of return.

Even though the period from 1966 to 1969 was one of searching for alternatives to the large public institution for the residential placement of mentally retarded persons, is it possible that during this period of three years the private alternatives grew fourfold? An equally important question, of course, is what constituted the operational definition of institution in the earlier studies. While the average daily residents for reporting private institutions in the NIMH surveys of 1963 and 1965 was 77 and 75 respectively, the survey found the 1969 average to be 47. This may suggest that many smaller facilities were not included by NIMH, perhaps in the absence of specific state licensing requirements for smaller facilities, but it no doubt, at least in part, was indicative of the rapid change taking place in the residential service system. At any rate, because of the return rates from these facilities and the more recent data acquired through the survey of the Master Facility Inventory, very little could be said about trends in the provision of private residential services to the mentally retarded at the beginning of the 1970s. (In Table 21 is shown the number of known private facilities and the percentage of these reporting demographic data on their residents from 1880 through 1969.)

There is no question that the recent trend toward moving mentally retarded persons out of public institutions has led to a rapid growth in the number of private facilities. According to the Developmental Disabilities Project survey, by June 30, 1977 there were 4,065 non-governmental facilities providing "24-hour, 7 days-a-week responsibility for room, board, and supervision of mentally retarded persons." The average size of these facilities was less than one-half that found in 1969. Again to what degree the differences between the 1969 and 1977 surveys reflected change in the service system versus change in the survey methods is not perfectly clear.

Table 21

Number of Known Facilities and Percent Reporting in Survey of Private Residential Facilities for the Mentally Retarded

Year	Number	% Reporting
1880	0	--
1890	4	100
1904	14	100
1910	28	100
1923	73	100
1933	81	93
1934	79	86
1935	76	87
1936	66	86
1937	64	84
1938	68	76
1939	77	71
1940	80	64
1941	109	64
1942	--	--
1943	--	--
1944	--	--
1945	120	77
1946	131	71
1947	146	74
1948	148	76
1949	145	86
1950	156	84
1951	168	76
1952	168	67
1953	156	74
1954	204	69
1955	190	70
1956	185	68
1957	182	66
1958	206	61
1959	200	65
1960	195	58
1961	192	44
1962	210	56
1963	200	48
1964	199	45
1965	191	44
1966	182	41
1969	708	

A FINAL COMMENT

It has been nearly one hundred years since the first census of mentally retarded persons in institutions was conducted. During the bulk of this period, surveys of institutions have documented a steady increase in the population of these facilities. In the last decade the trend has been reversed, and ever greater numbers of mentally retarded persons in residential facilities are living outside large, state-operated institutions. Today 70 percent of all public and community residential facilities contain ten or fewer residents. On the other side of the coin, however, it must be recognized that about 85 percent of all mentally retarded persons in the various public and community residential facilities are in settings with over thirty residents. Thousands more are in foster homes. In short, the residential service system has grown extremely complex in recent years. Still no ongoing mechanism for measuring quantitative change with that system, let alone the nature of care within the various alternatives, exists.

In this review the author has attempted to describe some of the methodologies utilized in the past to measure demographic and administrative factors among residential placement alternatives for mentally retarded persons. Hopefully this review will be useful not only in its summary of historical trends and practices, but will assist those who will plan for future mechanisms to assess the ways in which residential services are provided to mentally retarded persons.

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APPENDIX A

Enumerators' Schedules from 1860, 1880, 1890

Censuses of Idiotic and Feeble-minded Persons

1860 Census

Page No.

SCHEDULE 1.—Free Inhabitants in ______________________ in the County of ______________

State of ____________ enumerated by me, on the ________ day of __________, 1860.

Post Office ______________________

______________________, Ass't Marshal.

	Dwelling Houses—numbered in the order of visitation.	Families numbered in the order of visitation.	The name of every person whose usual place of abode on the first day of June, 1860, was in this family.	DESCRIPTION. Age.	Sex.	Color, {White, Black, or Mulatto.	Profession, Occupation, or Trade of each person, male and female, over 15 years of age.	VALUE OF ESTATE OWNED. Value of Real Estate.	Value of Personal Estate.	Place of Birth, Naming the State, Territory, or Country.	Married within the year.	Attended School within the year.	Persons over 20 years of age who can not read and write.	Whether deaf and dumb, blind, insane, idiotic, pauper, or convict.	
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	
1															1
39															39
40															40
			No. white males, ____ No. colored males, ____ No. foreign born, ____ No. blind, ____ No. white females, ____ No. colored females, ____ No. deaf and dumb, ____ No. insane, ____ 6—40							No. idiotic, ____ No. paupers, ____				No. convicts, ____	

1880 Census

SUPPLEMENTAL SCHEDULE No. 2.—IDIOTS residing in ......, in the County of ......, State of ......, enumerated by me June, 1880. ......, Enumerator.

Page No.; Supervisor's district No.; Enumeration district No.

Number taken from schedule No. 1:
1. Number of page.
2. Number of line.
3. Name.

Residence when at home (see note A):
4. City or town.
5. County (if in same State), or State (if in some other State).
6. Is this person self-supporting, or partly so? (See note B.)
7. Age at which idiocy occurred. (See note C.)
8. Supposed cause of idiocy (if acquired). (See note D.)
9. Size of head (large, small, or natural).

Training school:
10. Has this person ever been an inmate of a training school for idiots? If yes, name the said training school.
11. What has been the total length of time spent by him (or her) during life in any such training school or training schools?
12. Date of discharge (year only).

(See note E):
13. Is this person also insane?
14. Is he (or she) also blind?
15. Is he (or she) also deaf?
16. Is he (or she) also an epileptic?

Is he (or she) paralyzed; and if yes, on which side?
17. Right.
18. Left.

The object of this supplemental schedule is to furnish material not only for a complete enumeration of the idiots, but for an account of their condition. It is important that every inquiry respecting each case be answered as fully as possible. Enumerators will, therefore, after making the proper entries upon the Population Schedule (No. 1), transfer the name (with schedule page and number) of every idiot found, from schedule No. 1 to this special schedule, and proceed to ask the additional questions indicated in the headings of the several columns.

The word "idiot" has a special meaning which it is essential for every enumerator to know. An idiot is a person the development of whose mental faculties was arrested in infancy or childhood before coming to maturity. It is sometimes difficult to distinguish between the stupidity which results from idiocy and that which is due to the loss or deterioration of mental power in consequence of insanity. The latter is not true idiocy, but dementia or imbecility. The enumeration desired for the census is of true idiots only. Demented persons should be classed with the insane.

Enumerators may obtain valuable hints as to the number of idiots, and their residences, from physicians who practice medicine in their respective districts.

NOTE A.—An idiot may be found either at his own home or away from it in some institution, such as a training school, asylum, or poorhouse. In the latter case his residence when at home must be stated, in order that he may be accredited to the State or county to which he properly belongs, and that the county in which the institution is situated may not be charged with more than its due proportion of idiots.

NOTE B.—If self-supporting, say "Yes;" if partly self-supporting, say "Partly;" if not, say "No." Indicate all inmates of institutions who are maintained or treated at their personal expense (not at the expense of any town, county, or State, nor of the institution) by the word "Pay."

NOTE C.—If an idiot from birth, say "B;" if idiocy occurred after birth, state the age at which it occurred. Special pains should be taken to indicate all idiots from birth.

NOTE D.—The causes of idiocy are such as the following: Scarlet fever, measles, meningitis, etc., blow on head, fall, etc., fright, etc.

NOTE E.—In making entries in columns 13, 14, 15, 16, 17, and 18, an affirmative mark only will be used, thus: /

SUPPLEMENTAL SCHEDULE NO. 2.—STATISTICS OF FEEBLE-MINDEDNESS AND IDIOCY.

Feeble-minded and idiotic persons in......, County of......, State of......, enumerated in June, 1890. ......, Enumerator.
Supervisor's district No.; Enumeration district No.

[Inquiries numbered 1 to 22, inclusive, in general population schedule are common to this supplemental schedule and are not here reproduced.]

Physical defects:
23. Blind.
24. Deaf.
25. Able to speak so as to be readily understood (well), imperfectly (imp.), or not at all (not).
26. Whether crippled, maimed, or deformed.
27. Age or period of life at which mental defect occurred.
28. Supposed cause of mental defect.
29. Whether this person has received instruction in a special school for the feeble-minded. (Yes or no.)
If yes, give name and location of school:
30. Name of school.
31. Location of school.
32. Length of time spent by this person in such school.
33. Length of time spent by this person in other public institutions.
Whether paralyzed on right or left side, or both sides; if so, specify:
34. Right.
35. Left.
36. Whether this person has had, or now has, any insane or feeble-minded relatives.
Whether this person has had, or now has, any relatives, as mentioned below, who were insane or feeble-minded from infancy, with the number under each heading:
37. Brothers.
38. Sisters.
39. Father.
40. Mother.
41. Grandfather.
42. Grandmother.
43. Uncles.
44. Aunts.
45. First cousins.
46. Whether this person has any relatives who were blind or deaf from infancy.
Whether this person has had, or now has, any relatives, as mentioned below, who were blind or deaf from infancy, with the number under each heading:
47. Brothers.
48. Sisters.
49. Father.
50. Mother.
51. Grandfather.
52. Grandmother.
53. Uncles.
54. Aunts.
55. First cousins.
56. Whether wholly or partially supported by public or private charity, or by self, family, or relatives.
57. Residence when at home, giving State, county, and post-office address.

SPECIAL INSTRUCTIONS FOR FILLING SCHEDULE.

The object of this supplemental schedule is to furnish material for a complete enumeration of the feeble-minded and idiotic and an account of their condition. Enumerators will, after making the proper entries upon Population Schedule No. 1, transfer to this schedule the information called for by columns 1 to 26, inclusive, for every feeble-minded or idiotic person found, and proceed to ask the additional questions indicated in the headings of the columns numbered 27 to 57, inclusive.

Valuable hints as to the existence of feeble-minded and idiotic persons in the neighborhood and their residence may be obtained from physicians in the respective districts.

The instructions necessary to the proper filling out of the columns numbered 1 to 26, inclusive, are contained in the book of instructions to enumerators, a copy of which has been supplied. The following special instructions will serve as a guide in completing the information concerning feeble-minded and idiotic persons only, called for by the columns numbered 27 to 57, inclusive, in all cases where the inquiries are not self-explanatory.

Columns 32 and 33. Give the time in years and twelfths of years.

Columns 34 and 35. Write "Yes" or "No" in one or both columns, according to side or sides paralyzed.

Column 36. Write "Insane" or "Feeble-minded," as the case may be. If none, write "No."

Columns 37 to 45. Give the number in figures under each heading, if known. Write "No" if it is known there are no such relatives. Write "Unk." when it is unknown. With regard to grandfathers, grandmothers, uncles, aunts, and first cousins, indicate wherever possible whether the insane or feeble-minded relatives are on the fathers' side by the use of the letter "F," or mother's side by the use of the letter "M," or on both by the use of the letters "FM."

Column 46. Give the number, and indicate as follows: Blind, "B," or deaf "D," as the case may be. If none, write "No."

Columns 47 to 55. Same instructions as under 37 to 45, but as regards blind and deaf relatives specify blind by "B" and deaf by "D."

Column 56. Write "Wholly priv.," "Family," "Partially self," etc., as the case may be.

Column 57. A feeble-minded person or idiot may be found either at his home or away from it in some educational institution, asylum, or poorhouse. If away from his home, special care should be taken to give the State, county, and post-office, so that the person may be credited to the proper State or county.

APPENDIX B

Schedules from 1910 Census of Feeble-minded Patients in Institutions

DEPARTMENT OF COMMERCE AND LABOR
BUREAU OF THE CENSUS

SCHEDULE 1—FEEBLE-MINDED PATIENTS IN INSTITUTIONS ON JANUARY 1, 1910

State

County *Name of Institution*

	NAME OF PATIENT IN FULL.	SEX.	RACE.	AGE AT LAST BIRTH-DAY.	MARITAL CONDITION.	COUNTRY OF BIRTH OF PATIENT.	COUNTRY OF BIRTH OF PATIENT'S FATHER.	COUNTRY OF BIRTH OF PATIENT'S MOTHER.	For foreign born only. Years in United States.	FOR THE PHYSICALLY DEFECTIVE.					HOW SUPPORTED		
										Blind.	Deaf.	Crippled, maimed, or deformed.	Paralytic.	Epileptic.	At public expense.	At public and private expense.	At private expense.
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
1																	
2																	
3																	
4																	
5																	
6																	
7																	
8																	
9																	
10																	
11																	

Department of Commerce and Labor
BUREAU OF THE CENSUS

SPECIMEN SCHEDULE 2

FEEBLE-MINDED PATIENTS ADMITTED TO INSTITUTIONS DURING 1910

1. .... (State.) , ... (County.)

2. .... (Name of institution.)

3. *Smith, William* (Name of patient.)

4. Sex
   - *a* Male X
   - *b* Female

5. Race
   - *a* White X
   - *b* Black
   - *c* Mulatto
   - *d* Indian
   - *e* Chinese
   - *f* Japanese
   - *g* Other

6. Age at last birthday *12*

7. Marital condition.
   - *a* Single X
   - *b* Married
   - *c* Widowed
   - *d* Divorced
   - *e* Unknown

8. *U. S.* (Country of birth of patient.)

9. *Canada (French)* (Country of birth of patient's father.)

10. *Canada (French)* (Country of birth of patient's mother.)

11. How supported.
    - *a* At public expense X
    - *b* Partly at public and partly at private expense
    - *c* At private expense

FOR THE PHYSICALLY DEFECTIVE

12. Nature of defects.
    - *a* Blind
    - *b* Deaf
    - *c* Crippled, maimed, or deformed X
    - *d* Paralytic
    - *e* Epileptic

FOR FOREIGN-BORN ONLY

13. Time in the United States .... (Years.), ... (Months.)

PATIENTS ADMITTED TO INSTITUTIONS FOR THE FEEBLE-MINDED DURING 1910

INSTRUCTIONS FOR FILLING SCHEDULE 2

One card, "Schedule 2. Feeble-minded patients admitted to institutions during 1910," is to be filled in for each patient admitted to your institution during the year 1910. If a patient is admitted two or more times during a year, a card should be filled out for each admission.

THE SEVERAL INQUIRIES

Inquiry 1 asks for the state and county in which your institution is located.

Inquiry 2 asks for the name of your institution.

Inquiry 3 asks for the patient's name. The name should be given in full.

Inquiry 4 calls for a statement of the patient's sex. It is to be answered by placing a cross (X) on the appropriate line.

Inquiry 5 asks the race of the patient. It is to be answered by placing a cross on the appropriate line. Note that for the purposes of the census the term "black" includes all negroes of full blood, while the term "mulatto" includes all persons not full-blooded negroes but having some proportion or trace of negro blood and regarded as negroes in the community in which they live.

Inquiry 6 asks for a statement of the patient's age at his last birthday.

Inquiry 7 asks whether the patient is single, married, widowed, or divorced. It is to be answered by placing a cross on the proper line.

Inquiry 8 calls for the country of birth of the patient. If the patient is a native, write U. S. If he was born in a foreign country, give the name of the country. Use England, Ireland, Scotland, or Wales, as the case may be, instead of Great Britain; and Norway, Sweden, or Denmark instead of Scandinavia. Distinguish between Austria and Hungary; between Canada (French) and Canada (English); also between Poland (German), Poland (Austrian), and Poland (Russian).

Inquiry 9 asks the country of birth of the patient's father. The general instructions for Inquiry 8 apply to this inquiry also.

Inquiry 10 asks the country of birth of the patient's mother. The general instructions for Inquiry 8 again apply.

Inquiry 11 asks whether the patient is supported (*a*) at public expense, (*b*) partly at public and partly at private expense, or (*c*) at private expense. Answer by placing a cross on the appropriate line.

Inquiry 12 applies only to patients who are blind; deaf; crippled, maimed, or deformed; paralytic; or epileptic. Indicate the particular one of these defects from which the patient is suffering by placing a cross on the appropriate line. If the patient is suffering from two or more defects, indicate each defect from which he suffers.

Inquiry 13, which applies only to the foreign-born, calls for a statement of the number of years the patient has resided in the United States. If the patient has been in this country less than one year, indicate the number of months.

APPENDIX C

Schedules from Government Agency Annual Surveys of Residents in Institutions for the Mentally Retarded (1923-1970)

1923 CENSUS

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

INSTITUTIONS FOR THE FEEBLE-MINDED.

INSTRUCTIONS FOR FILLING SCHEDULES.

SCHEDULES TO BE FILLED.

SCHEDULE 1.—Patients resident in institutions December 31, 1922.

One card, Schedule 1, is to be filled for **each patient admitted prior to January 1, 1922**, who was present in your institution at midnight December 31, 1922. For those admitted or readmitted during the year 1922, either Schedule 2 or 3 is to be used. In such cases the answers given on Schedules 2 and 3 will supply the information required for completing the enumeration of all patients resident in your institution December 31, 1922, excluding, of course, all patients reported on Schedules 4 and 5 as having been discharged or as having died prior to that date. As a punch card is used for tabulation purposes in the Bureau of the Census, the information required can be punched from one card as well as another, and thus the duplication of entries on Schedule 1 of patients already listed on Schedules 2 and 3 becomes unnecessary.

This schedule should not be filled in for patients away from the institution on parole or otherwise absent on December 31, 1922.

SCHEDULE 2.—First admissions, Admitted during 1922.

One card, Schedule 2, is to be filled in for each **first admission** admitted to your institution during the calendar year 1922.

A **first admission** is a patient admitted for the first time to any institution for the feeble-minded, except institutions for temporary care.

SCHEDULE 3.—Readmissions, Readmitted during 1922.

One card, Schedule 3, is to be filled in for each **readmission** admitted to your institution during the calendar year 1922.

A **readmission** is a patient admitted who has been previously under treatment in an institution for the feeble-minded, except transfers and patients who have received treatment only in institutions for temporary care.

Patients returned from parole or escape are not to be counted as readmissions.

SCHEDULE 4.—Patients discharged or placed on indefinite parole during 1922.

One card, Schedule 4, is to be filled in for each patient discharged from your institution or placed on indefinite parole during the year 1922.

Patients placed on ordinary parole (not indefinite parole) or transferred to other institutions for the feeble-minded or who die in the institution are not to be reported on Schedule 4. Schedule 5 is to be used for deaths in the institution.

SCHEDULE 5.—Patients dying during 1922.

One card, Schedule 5, is to be filled in for each patient who died in your institution during the calendar year 1922.

Patients who died on parole are to be reported as discharged on Schedule 4.

SCHEDULE 6.—Movement of patient population, 1922.

This schedule is to be filled in as soon as possible after the close of the calendar year 1922. This schedule should balance and the number of patients resident in your institution on December 31, 1922, and the number of first admissions, readmissions, discharges, and deaths, respectively, should agree with the number of the corresponding schedules filled in.

No schedules are required for patients absent from the institution on December 31, 1922, or for patients transferred between your institution and other institutions for the feeble-minded in same state.

8—5215

GENERAL INSTRUCTIONS.

The schedules should be filled in as promptly as possible and returned to the Bureau of the Census by mail.

Before forwarding the schedules they should be carefully checked back to see that all are properly filled in and that the number of schedules agrees with the number of patients present in the institution and the number of first admissions, readmissions, discharges, and deaths, respectively, as reported on Schedule 6.

The schedules should be filled in with typewriter or in plain writing with black ink.

Every inquiry on each schedule should be answered. If the information called for by any inquiry can not be ascertained, write "Unknown" in the space provided.

Most of the inquiries are self-explanatory, but for certain of the inquiries special instructions are provided below. These instructions are given under the name of the subject, which is common to several schedules, and not by the number of the inquiry, which often varies on the different schedules. If these instructions and those given on the schedules themselves are carefully observed, your work and that of the Bureau of the Census will be greatly reduced and the necessity of further correspondence will be avoided.

SPECIAL INSTRUCTIONS.

Mental status of patient.—In designating such status use the terms "Idiot," "Imbecile," "Moron," "Not feeble-minded," and "Unclassified."

An ***idiot*** is a mentally defective person having a mental age of not more than 35 months, or, if a child, an intelligence quotient of less than 25.

An ***imbecile*** is a mentally defective person having a mental age between 36 months and 83 months, inclusive, or, if a child, an intelligence quotient between 25 and 49.

A ***moron*** is a mentally defective person having a mental age between 84 months and 143 months, inclusive, or, if a child, an intelligence quotient between 50 and 74.

Race.—If the patient does not belong to any of the races specified, write the name of the race to which he, or she, belongs in the space provided. The term "Negro" includes all Negroes of full blood and all Negroes having some proportion of white blood.

Age at last birthday.—This question calls for the age in completed years at last birthday. In many cases persons will report the age in round numbers, like 30 or 45, or "about 30" or "about 45," when that is not the exact age. Therefore, when an age ending in 0 or 5 is reported, you should ascertain whether it is the exact age. If, however, it is impossible to get the exact age, enter the approximate age rather than return the age as unknown.

Country of birth.—Give the name of the country according to present geographical boundaries if possible. Do not use inclusives such as Great Britain, but write England, Scotland, or Wales.

The following is a list of the principal countries which are likely to be reported as the country of birth of foreign-born patients:

Africa.
Armenia.
Australia.
Austria.
Belgium.
Bulgaria.
Canada.
Central America.
China.
Czechoslovakia.
Cuba.
Denmark.
England.
Finland.
France.
Germany.
Greece.
Hungary.
India.
Ireland.
Italy.
Japan.
Jugoslavia.
Lithuania.
Luxemburg.
Mexico.
Norway.
Netherlands (Holland).
Poland.
Portugal.
Rumania.
Russia.
Scotland.
South America.
Spain.
Sweden.
Switzerland.
Syria.
Turkey in Asia.
Turkey in Europe.
Wales.
Other (specify).

Citizenship.—For a foreign-born person 21 years of age and over write "*Naturalized*," if the patient has taken out second or final naturalization papers, or has become a citizen of the United States while a minor through the naturalization of parents or (in case of a woman) by marriage with a citizen of the United States; "*First papers*," if patient has declared intention of becoming an American citizen and has taken out "first papers;" "*Alien*," if patient has taken no step toward becoming an American citizen.

Time in United States.—If foreign-born patient has been in United States one year or more, give time in completed years, or, if time is less than one year, in completed months.

Number of times admitted.—Give the number of times the patient has been admitted to institutions for the feeble-minded, including the last admission. Transfers, and returns from parole, should not be counted as admissions.

Total time spent in institutions.—This inquiry seeks to determine the total time which the patient has spent in institutions for the feeble-minded, whether that time was spent in your institution or in some other institution. If the time spent by a patient in other institutions for the feeble-minded can not be ascertained, give the total time spent in your institution and write, in addition, "Other unknown."

Classification of epileptics.—For patients reported as suffering from epilepsy, the terms "symptomatic" or "idiopathic" should be used in making such classification.

The term ***symptomatic*** includes only those cases of epilepsy in which it is decided that the seizures are symptoms of a definite disease.

The term ***idiopathic*** includes those cases of epilepsy in which the underlying cause of the spasmophilia is unknown.

Did patient prior to admission reside in a distinctly rural community?—The object of this inquiry is to obtain statistics which will throw some light on the relative prevalence of mental defect in urban and rural districts. In answering this question, all incorporated cities, villages, or boroughs having 2,500 inhabitants or more are to be considered urban. Smaller cities or villages are to be considered rural. In case of doubt give name of the city or village in the space provided therefor.

Indefinite parole.—This term signifies the relationship to the institution of a patient whose parole is continued indefinitely beyond the trial limit fixed by the institution. A patient on indefinite parole should not be considered on the books of the institution.

Cause of death.—Give the cause of death in accordance with the International List of Causes of Death.

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

INSTITUTIONS FOR FEEBLE-MINDED
SCHEDULE 1

PATIENTS RESIDENT IN INSTITUTIONS DEC. 31, 1922

1. ______ (State.) ______ (County.)

2. ______ (Name of institution.)

3. ______ (Name of patient.)

4. Date of last admission:

______ (Month.) ______ (Day.) ______ (Year.)

5. Mental status of patient ______ (Use classification of American Association for the Study of the Feeble-minded.)

6. Sex ______ (Male or Female—specify which.)

7. Race ______ (White, Negro, Indian, Chinese, or Japanese—specify which.)

8. Age at last birthday ______ years.

9. Marital condition ______ (Single, Married, Widowed, or Divorced—specify which.)

For native-born patients:

10. Was patient born in U. S.? ______ (Yes or No.)

11. Was patient's father born in U. S.? ______ (Yes or No.)

12. Was patient's mother born in U. S.? ______ (Yes or No.)

For foreign-born patients:

13. Country of birth of patient ______

14. Citizenship of patient ______ (Naturalized, First papers, or Alien—specify which.)

15. Time in United States ______ (Years.) ______ (Months.)

16. Number of times admitted to institutions for the feeble-minded ______

17. Total time spent in institutions for the feeble-minded ______ (Years.) ______ (Months.)

18. Is patient suffering from epilepsy? ______ (Yes or No.)

If "Yes," specify whether Symptomatic or Idiopathic:

______

8-5164 [U 1-894] GOVERNMENT PRINTING OFFICE 11—8087

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

INSTITUTIONS FOR FEEBLE-MINDED
SCHEDULE 2

FIRST ADMISSIONS, ADMITTED DURING 1922

1. ______ (State.) ______ (County.)

2. ______ (Name of institution.)

3. ______ (Name of patient.)

4. Admitted ______ (Month.) ______ (Day.), 1922.

5. Mental status of patient ______ (Use classification of American Association for the Study of the Feeble-minded.)

6. Sex ______ (Male or Female—specify which.)

7. Race ______ (White, Negro, Indian, Chinese, or Japanese—specify which.)

8. Age when admitted (last birthday) ______ years.

9. Marital condition ______ (Single, Married, Widowed, or Divorced—specify which.)

For native-born patients:

10. Was patient born in U. S.? ______ (Yes or No.)

11. Was patient's father born in U. S.? ______ (Yes or No.)

12. Was patient's mother born in U. S.? ______ (Yes or No.)

For foreign-born patients:

13. Country of birth of patient ______

14. Citizenship of patient ______ (Naturalized, First papers, or Alien—specify which.)

15. Time in United States ______ (Years.) ______ (Months.)

16. Did patient prior to admission reside in a distinctly rural community? ______ (Yes or No.)

17. If answer to 16 is "No," give name of village, town, or city in which patient resided:

______

18. Is patient suffering from epilepsy? ______ (Yes or No.)

If "Yes," specify whether Symptomatic or Idiopathic:

______

8-5165 [U 2-895] GOVERNMENT PRINTING OFFICE 11—8087

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

INSTITUTIONS FOR EPILEPTICS
SCHEDULE 3

READMISSIONS, READMITTED DURING 1922

1. ______________ (State.) ______________ (County.)

2. ______________ (Name of institution.)

3. ______________ (Name of patient.)

4. Readmitted ______________ (Month.) ______ (Day.), 1922.

5. Epileptic classification of patient ______________ (Symptomatic, Idiopathic, or Nonepileptic—specify which.)

6. Mental status of patient ______________ (Idiot, Imbecile, Moron, Not feeble-minded, or Unclassified—specify which.)

7. Sex ______________ (Male or Female—specify which.)

8. Race ______________ (White, Negro, Indian, Chinese, or Japanese—specify which.)

9. Age when readmitted (last birthday) ______ years.

10. Marital condition ______________ (Single, Married, Widowed, or Divorced—specify which.)

For native-born patients:

11. Was patient born in U. S.? ______ (Yes or No.)

12. Was patient's father born in U. S.? ______ (Yes or No.)

13. Was patient's mother born in U. S.? ______ (Yes or No.)

For foreign-born patients:

14. Country of birth of patient ______________

15. Citizenship of patient ______________ (Naturalized, First papers, or Alien—specify which.)

16. Time in United States ______ (Years.) ______ (Months.)

17. Number of times admitted to institutions for epilepsy, or mental disease or defect ______

18. Total time spent in institutions for epilepsy, or mental disease or defect ______ (Years.) ______ (Months.)

19. Alcoholic habits of patient ______________ (Abstinent, Temperate, or Intemperate—specify which.)

20. Was patient in the military or naval service of the United States during the World War? ______ (Yes or No.)

S-5170 [W 5-903] GOVERNMENT PRINTING OFFICE 11—8119

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

INSTITUTIONS FOR EPILEPTICS
SCHEDULE 4

PATIENTS DISCHARGED OR PLACED ON INDEFINITE PAROLE DURING 1922

1. ______________ (State.) ______________ (County.)

14. Number of times admitted to institutions for epilepsy, or mental disease or defect ______

15. Was patient in the military or naval service of the United States during the World War? ______ (Yes or No.)

S-517b [W 5-905] GOVERNMENT PRINTING OFFICE 11—8117

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

INSTITUTIONS FOR EPILEPTICS
SCHEDULE 5

PATIENTS DYING DURING 1922

1. ______________ (State.) ______________ (County.)

14. Number of times admitted to institutions for epilepsy, or mental disease or defect ______

15. Was patient in the military or naval service of the United States during the World War? ______ (Yes or No.)

S-517b [W 5-905] GOVERNMENT PRINTING OFFICE 11—8117

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

INSTITUTIONS FOR FEEBLE-MINDED
SCHEDULE 6

MOVEMENT OF PATIENT POPULATION, 1922

(State.) (County.)

(Name of institution.)

	Males.	Females.	Total.
Patients on books Jan. 1, 1922:			
In institution			
On temporary leave			
Total			
Admitted during year:			
First admissions			
Readmission			
Transfers from other institutions for feeble-minded in same state			
Total received during year			
Total in institution during year			
Discharged or placed on indefinite parole during year			
Transferred to other institutions for feeble-minded in same state			
Died during year			
Total discharged, transferred, and died during year			
Patients on books Dec. 31, 1922:			
In institution			
On temporary leave			
Total			
Average daily resident patient population during year			

8-5169 [U 6-899] GOVERNMENT PRINTING OFFICE 11—5091

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

INSTITUTIONS FOR EPILEPTICS
SCHEDULE 6

MOVEMENT OF PATIENT POPULATION, 1922

(State.) (County.)

(Name of institution.)

	Males.	Females.	Total.
Patients on books Jan. 1, 1922:			
In institution			
On parole or otherwise absent but still on books			
Total			
Admitted during year:			
First admissions			
Readmissions			
Transfers from other institutions for epileptics in same state			
Total received during year			
Total on books during year			
Discharged during year:			
As recovered			
As improved			
As unimproved			
As nonepileptic			
Otherwise discharged			
Total discharged during year			
Transferred to other institutions for epileptics in same state			
Died during year			
Total discharged, transferred, and died during year			
Patients on books Dec. 31, 1922:			
In institution			
On parole or otherwise absent but still on books			
Total			
Average daily resident patient population during year			

8-5179 [W 6-906] GOVERNMENT PRINTING OFFICE 11—5110

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

INSTITUTIONS FOR FEEBLE-MINDED

SCHEDULE 7

GENERAL INFORMATION

As of December 31, 1922.

(Name of Institution.)

(State.) (County.)

1. Date of *opening* as an institution for feeble-minded

2. Type of institution: State, county, endowed private, or unendowed private

3. Institution plant:

Value of institution property—

Real estate (including buildings) $

Personal property

Total $

Total acreage of main institution property—

Owned Rented

(Includes grounds, farm and garden, and sites occupied by buildings.)

Colonies—

Owned, number , total acreage

Rented, number , total acreage

Total acreage under cultivation during year

(Includes land owned and rented at main institution and colonies.)

4. Officers and employees:	Actually in service at end of year.		
	Males.	Females.	Total.
Superintendents			
Assistant superintendents			
Pathologists			
Other staff physicians			
Psychologists			
Resident dentists			
Principal of school			
Teachers of grade subjects			
Teachers of special subjects			
Social workers			
Stewards			
Graduate nurses			
Matrons			
Attendants			
All other officers and employees			
Total officers and employees			

8-5200 [U 7-919] GOVERNMENT PRINTING OFFICE

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

INSTITUTIONS FOR FEEBLE-MINDED

SCHEDULE 8

FINANCIAL STATEMENT

FOR THE FISCAL YEAR ENDING ______________________, 1922.
(Give exact date.)

____
(Name of Institution.)

______________________ ______________________
(State.) (County.)

RECEIPTS.

Balance on hand from previous fiscal year __________ $__________

Received from appropriations __________ __________

Received from paying patients __________ __________

Received from all other sources __________ __________

Total receipts __________ __________

DISBURSEMENTS.

1. EXPENDITURES FOR ***maintenance*** OF PATIENTS:
(Under this heading *should be included* all expenditures for maintenance of patients and of plant. Expenditures for extraordinary repairs or improvements *should not be* included.)

Salaries and wages __________ $__________

Provisions (food) __________ __________

Fuel, light, and water __________ __________

All other expenditures for maintenance __________ __________

Total expenditures for maintenance __________ __________

2. EXPENDITURES FOR PURPOSES OTHER THAN MAINTENANCE, INCLUDING NEW BUILDINGS, ADDITIONS, EXTRAORDINARY REPAIRS, IMPROVEMENTS, ETC. __________ __________
(Under this heading should be placed all expenditures for items, such as additional land [bought or reclaimed], new buildings, new equipment [not replacements], etc., which represent not restorations but improvements or additions to plant.)

3. EXPENDITURES FOR REPAYMENT OF LOANS AND INTEREST ON LOANS __________ __________

Total expenditures __________ __________

Amount returned to state treasurer or other officials __________ __________

Balance on hand at close of year __________ __________
(Includes balance for maintenance and for all other purposes.)

Total disbursements, including balance on hand __________ __________
(This item should equal total receipts.)

8-5201 [U 8-920] GOVERNMENT PRINTING OFFICE

1947 Census

PHS-808(MH) OLD NUMBER 1-DE
REV. 12-47

FEDERAL SECURITY AGENCY
U. S. PUBILC HEALTH SERVICE

BUDGET BUREAU NO. 68-R332
APPROVAL EXPIRES DECEMBER 31, 1948

INSTITUTIONS FOR MENTAL DEFECTIVES AND EPILEPTICS
MOVEMENT OF POPULATION: 1947

REPORT FOR THE YEAR ENDING (Give exact date) 1947

To: U. S. Public Health Service,
Mental Hygiene Division, Washington 25, D. C.

NAME OF INSTITUTION

INSTRUCTIONS - Send one (1) copy of this form to the above address not later than March 1, 1948.

ADDRESS (Street, City, Zone, State)

ITEM	ITEM	TOTAL POPULATION			MENTAL DEFECTIVES		EPILEPTICS		NEITHER MENTALLY DEFECTIVE NOR EPILEPTIC	
		TOTAL (a)	MALE (b)	FEMALE (c)	MALE (d)	FEMALE (e)	MALE (f)	FEMALE (g)	MALE (h)	FEMALE (i)
1	PATIENTS ON BOOKS AT BEGINNING OF YEAR IN INSTITUTION									
2	IN FAMILY CARE (PUBLIC INSTITUTIONS ONLY)									
3	ON PAROLE OR OTHERWISE ABSENT BUT STILL CARRIED ON BOOKS									
4	*TOTAL ON BOOKS AT BEGINNING OF YEAR (sum of Items 1,2,&3)*									
5	ADMISSIONS DURING YEAR *(Do not include those returned from parole, visit or escape)* FIRST ADMISSIONS									
6	READMISSIONS									
7	TRANSFERS FROM OTHER INSTITUTIONS FOR MENTAL DEFECTIVES & EPILEPTICS WITHIN THE STATE									
8	*TOTAL ADMISSIONS (sum of Items 5, 6, and 7)*									
9	SUM OF ITEMS 4 AND 8 *(for checking)*									
10	SEPARATIONS DURING YEAR *(Do not include paroles, visits, or escaped unless discharged from books)* DISCHARGES DIRECT FROM INSTITUTIONS									
11	WHILE ON PAROLE									
12	*TOTAL DISCHARGES (sum of Items 10 and 11)*									
13	TRANSFERS TO OTHER INSTITUTIONS FOR MENTAL DEFECTIVES AND EPILEPTICS WITHIN THE STATE									
14	DEATHS IN INSTITUTION									
15	DEATHS OF PATIENTS ON PAROLE OR OTHERWISE ABSENT FROM INSTITUTION									
16	*TOTAL SEPARATIONS (sum of Items 12, 13, 14, and 15)*									
17	PATIENTS ON BOOKS AT END OF YEAR IN INSTITUTION									
18	IN FAMILY CARE (PUBLIC INSTITUTIONS ONLY)									
19	ON PAROLE OR OTHERWISE ABSENT BUT STILL CARRIED ON BOOKS									
20	*TOTAL ON BOOKS AT END OF YEAR (sum of Items 17, 18, and 19)*									
21	SUM OF ITEMS 16 AND 20 *(should equal Item 9 if all entries are correct)*									

22	AVERAGE DAILY TOTAL PATIENT POPULATION IN INSTITUTION DURING YEAR	
23	AVG. DAILY MENTALLY DEFECTIVE POPULATION IN INST. DURING YEAR	
24	AVG. DAILY EPILEPTIC POPULATION IN INSTITUTION DURING YEAR	
25	RATED TOTAL CAPACITY OF INSTITUTION	

REPORT FURNISHED BY

SIGNATURE

TITLE

PHS-505(MH)
OLD NUMBER 2-D
REV. 12-47

FEDERAL SECURITY AGENCY
U. S. PUBLIC HEALTH SERVICE
MENTAL DEFECTIVES

BUDGET BUREAU NO. 68-R334
APPROVAL EXPIRES DECEMBER 31, 1948

REPORT FOR YEAR ENDING (Give exact date) 1947

NAME OF HOSPITAL

ADDRESS (Street, City, Zone, State)

FIRST ADMISSIONS DURING THE YEAR, BY SEX, MENTAL STATUS, AND CLINICAL DIAGNOSIS: 1947

To: U. S. Public Health Service,
Mental Hygiene Division, Washington 25, D. C.

INSTRUCTIONS - Send *one (1)* copy of this form to the above address not later than *March 1, 1948*.

ITEM #	CLINICAL DIAGNOSIS	TOTAL MENTALLY DEFECTIVE			IDIOT		IMBECILE		MORON		UNCLASSIFIED	
		TOTAL (a)	MALE (b)	FEMALE (c)	MALE (d)	FEMALE (e)	MALE (f)	FEMALE (g)	MALE (h)	FEMALE (i)	MALE (j)	FEMALE (k)
1	FAMILIAL											
2	MONGOLISM											
3	WITH DEVELOPMENTAL CRANIAL ANOMALIES											
4	WITH CONGENITAL CEREBRAL SPASTIC INFANTILE PARALYSES											
5	POSTINFECTIONAL											
6	POSTTRAUMATIC											
7	WITH EPILEPSY											
8	WITH ENDOCRINE DISORDER											
9	WITH FAMILIAL AMAUROSIS											
10	WITH TUBEROUS SCLEROSIS											
11	WITH OTHER ORGANIC NERVOUS DISEASE											
12	OTHER FORMS											
13	UNDIFFERENTIATED											
14	UNKNOWN											
15	*TOTAL (should agree with Item 5, Mental Defectives, Form 1)*											

REPORT FURNISHED BY

DATE SIGNATURE TITLE

PHS-509 (MH)
OLD NUMBER 2-DE
REV. 12-47

FEDERAL SECURITY AGENCY
U. S. PUBLIC HEALTH SERVICE

BUDGET BUREAU NO. 68-R333
APPROVAL EXPIRES DECEMBER 31, 1948

REPORT FOR YEAR ENDING *(Give exact date)*

NAME OF INSTITUTION

ADDRESS *(Street, City, Zone, State)*

INSTITUTIONS FOR MENTAL DEFECTIVES
AND EPILEPTICS

FIRST ADMISSIONS, DURING THE YEAR BY SEX, AND TYPE OF MENTAL DISORDER: 1947

To: U. S. Public Health Service,
Mental Hygiene Division, Washington 25, D. C.

INSTRUCTIONS

Send *one (1)* copy of this form to the above address not later than *March 1, 1948*. Report on this form *all first admissions only*. *Do not* report patients admitted by transfer or patients returned from parole, escape, or visit.

ITEM NO.	MENTAL DIAGNOSIS	TOTAL (a)	MALE (b)	FEMALE (c)
	MENTAL DEFECTIVES			
1	IDIOT			
2	IMBECILE			
3	MORON			
4	UNCLASSIFIED AND UNKNOWN MENTAL DEFECTIVES			
5	*TOTAL MENTAL DEFECTIVES*			
	EPILEPTICS			
6	SYMPTOMATIC			
7	IDIOPATHIC			
8	UNCLASSIFIED AND UNKNOWN EPILEPTICS			
9	*TOTAL EPILEPTICS*			
	NEITHER MENTALLY DEFECTIVE NOR EPILEPTIC			
10	UNCLASSIFIED			
11	OTHER *(Specify)*			
12				
13	*TOTAL, NEITHER MENTALLY DEFECTIVE NOR EPILEPTIC*			
14	*GRAND TOTAL, ALL CLASSES*			

REPORT FURNISHED BY

DATE　　SIGNATURE　　TITLE

PHS-506(MH)
OLD NUMBER 3-D
REV. 12-47

FEDERAL SECURITY AGENCY
U. S. PUBLIC HEALTH SERVICE

BUDGET BUREAU NO. 68-R336
APPROVAL EXPIRES DECEMBER 31, 1948

REPORT FOR YEAR ENDING (Give exact date)
1947

NAME OF HOSPITAL

ADDRESS (Street, City, Zone, State)

MENTAL DEFECTIVES

FIRST ADMISSIONS, DURING THE YEAR, BY MENTAL STATUS, SEX, AND AGE: 1947

To: U. S. Public Health Service,
Mental Hygiene Division, Washington 25, D. C.

INSTRUCTIONS - Send one (1) copy of this form to the above address not later than March 1, 1948.

ITEM NO.	AGE GROUPS	TOTAL MENTALLY DEFECTIVE			IDIOT		IMBECILE		MORON		UNCLASSIFIED	
		TOTAL (a)	MALE (b)	FEMALE (c)	MALE (d)	FEMALE (e)	MALE (f)	FEMALE (g)	MALE (h)	FEMALE (i)	MALE (j)	FEMALE (k)
1	UNDER 5 YEARS											
2	5 TO 9 YEARS											
3	10 TO 14 YEARS											
4	15 TO 19 YEARS											
5	20 TO 24 YEARS											
6	25 TO 29 YEARS											
7	30 TO 39 YEARS											
8	40 TO 49 YEARS											
9	50 TO 59 YEARS											
10	60 YEARS AND OVER											
11	UNKNOWN											
12	TOTAL (should agree with Item 5, Mental Defectives, Form 1)											

REPORT FURNISHED BY

DATE　　SIGNATURE　　TITLE

S-507(MH)
OLD NUMBER 4-D
REV. 12-47

FEDERAL SECURITY AGENCY
U. S. PUBLIC HEALTH SERVICE

BUDGET BUREAU NO. 68-R338
APPROVAL EXPIRES DECEMBER 31, 1948

REPORT FOR YEAR ENDING (Give exact date)

1947

NAME OF INSTITUTION

MENTAL DEFECTIVES

ALL DISCHARGES DURING THE YEAR, BY MENTAL STATUS, SEX, AND CONDITION ON DISCHARGE: 1947

To: U. S. Public Health Service,
Mental Hygiene Division, Washington 25, D. C.

ADDRESS (Street, City, Zone, State)

INSTRUCTIONS - Send one (1) copy of this form to the above address not later than March 1, 1948.

ITEM NO.	CONDITION ON DISCHARGE	TOTAL MENTALLY DEFECTIVE (a)	IDIOT (b)	IMBECILE (c)	MORON (d)	UNCLASSIFIED (e)
	MALE					
1	15 YEARS OLD AND OVER					
2	CAPABLE OF SELF-SUPPORT					
3	CAPABLE OF PARTIAL SELF-SUPPORT					
4	INCAPABLE OF PRODUCTIVE WORK					
5	UNKNOWN					
6	UNDER 15 YEARS					
7	UNKNOWN AGE					
8	TOTAL (should agree with Item 12, Mental Defectives, Form 1)					
	FEMALE					
9	15 YEARS OLD AND OVER					
10	CAPABLE OF SELF-SUPPORT					
11	CAPABLE OF PARTIAL SELF-SUPPORT					
12	INCAPABLE OF PRODUCTIVE WORK					
13	UNKNOWN					
14	UNDER 15 YEARS					
15	UNKNOWN AGE					
16	TOTAL (should agree with Item 12, Mental Defectives, Form 1)					
17	GRAND TOTAL					

REPORT FURNISHED BY

DATE | SIGNATURE | TITLE

PHS-818(MH)
OLD NUMBER 8-H-DE
REV. 12-47

HOSPITALS FOR MENTAL DISEASE
INSTITUTIONS FOR MENTAL DEFECTIVES AND EPILEPTICS
ADMINISTRATIVE STAFF: 1947

FEDERAL SECURITY AGENCY
U. S. PUBLIC HEALTH SERVICE

REPORT FOR YEAR ENDING (Give exact date) 1947

BUDGET BUREAU NO. 68-R330
APPROVAL EXPIRES DEC. 31, 1948

NAME OF INSTITUTION OR HOSPITAL

ADDRESS (Street, City, Zone, State)

To: U. S. Public Health Service, Mental Div., Wash. 25, D. C.

INSTRUCTIONS – Send one (1) copy of this form to the above address by March 1, 1948.

ITEM NO.	CLASS OF OFFICERS AND EMPLOYEES	FULL-TIME POSITIONS				PART-TIME EMPLOYEES[2]	
		AVAILABLE (Quota)[1]	FILLED (Employees actually in service at end of year)		VACANT	MALE	FEMALE
			MALE	FEMALE			
		(a)	(b)	(c)	(d)	(e)	(f)
1	SUPERINTENDENT OR CHIEF ADMINISTRATOR						
2	ASSISTANT SUPERINTENDENT						
3	CLINICAL DIRECTOR (IN-PATIENT SERVICE)						
4	PATHOLOGIST						
5	MEDICAL SPECIALISTS (CARDIOLOGIST, ROENTGENOLOGISTS, ETC.)						
6	STAFF PHYSICIANS						
7	CONSULTING PHYSICIANS	XXXX	XXXX	XXXX	XXXX		
8	MEDICAL INTERNES						
9	STEWARDS, ASSISTANT STEWARDS, AND BUSINESS MANAGERS						
10	PSYCHOLOGISTS AND PSYCHOMETRISTS						
11	DENTISTS						
12	DENTAL ASSISTANTS						
13	PHARMACISTS						
14	CLINICAL ASSISTANTS						
15	LABORATORY AND X-RAY TECHNICIANS						
16	PRINCIPALS OF SCHOOLS						
17	TEACHERS OF GRADE SUBJECTS						
18	TEACHERS OF SPECIAL SUBJECTS						
19	GRADUATE NURSES						
20	OTHER NURSES (INCLUDING STUDENT NURSES)						
21	MATRONS AND ASSISTANT MATRONS (EXCLUDING GRADUATE NURSES)						
22	SUPERVISORS AND ASSISTANT SUPERVISORS OF WARD SERVICE (EXCLUDING GRADUATE NURSES)						
23	ATTENDANTS						
24	OCCUPATIONAL THERAPISTS AND ASSISTANTS						
25	HYDROTHERAPISTS AND ASSISTANTS						
26	PHYSIOTHERAPISTS AND ASSISTANTS						
27	INDUSTRIAL SUPERVISORS AND INSTRUCTORS						
28	OTHER THERAPISTS AND ASSISTANTS						
29	DIETITIANS						
30	PSYCHIATRIC SOCIAL WORKERS						
31	OTHER TRAINED SOCIAL WORKERS						
32	FIELD WORKERS						
33	CLERICAL EMPLOYEES, INCLUDING STENOGRAPHERS AND BOOKKEEPERS						
34	ALL OTHER EMPLOYEES (KITCHEN, DOMESTIC, FARM, ETC.)						
35							
36							
37	TOTAL OFFICERS AND EMPLOYEES						

[1] Total positions for which funds are available.
[2] Part-time employees are those REGULARLY employed on a part-time basis. Temporary relief workers, if any, are not to be included.

PHS-518(MH)
OLD NUMBER 7-M-DE
REV. 12-47

FEDERAL SECURITY AGENCY
U. S. PUBLIC HEALTH SERVICE

BUDGET BUREAU NO. 68-R332
APPROVAL EXPIRES DECEMBER 31, 1948

HOSPITALS FOR MENTAL DISEASE INSTITUTIONS FOR MENTAL DEFECTIVES AND EPILEPTICS

FINANCIAL STATEMENT: 1947

REPORT FOR YEAR ENDING *(Give exact date)*

1947

NAME OF HOSPITAL OR INSTITUTION

ADDRESS *(Street, City, Zone, State)*

To: U. S. Public Health Service
Mental Hygiene Division, Washington 25, D. C.

INSTRUCTIONS – Send *one (1)* copy of this form to the above address not later than *March 1, 1948.*

ITEM NO.	ITEM	AMOUNT (Dollars)	AMOUNT (Dollars)
	RECEIPTS		
1	BALANCE ON HAND FROM PREVIOUS FISCAL YEAR *(Include balance for maintenance and for all other purposes)*		
2	RECEIVED FROM APPROPRIATIONS		
3	RECEIVED FROM PAYING PATIENTS		
4	RECEIVED FROM OTHER GOVERNMENTAL SOURCES		
5	RECEIVED FROM ALL OTHER SOURCES		
6	*TOTAL RECEIPTS (sum of items 1, 2, 3, 4, and 5)*		
	DISBURSEMENTS		
	EXPENDITURES FOR MAINTENANCE *(Under this heading should be included all expenditures for maintenance of patients and of plant, including ordinary repairs. Expenditures for additions and permanent repairs or improvements should not be included.)*		
7	SALARIES AND WAGES		XXXXX
8	PURCHASED PROVISIONS (FOOD)		XXXXX
9	FUEL, LIGHT, AND WATER		XXXXX
10	ALL OTHER EXPENDITURES FOR MAINTENANCE		XXXXX
11	*TOTAL EXPENDITURES FOR MAINTENANCE (sum of items 7, 8, 9, and 10)*		
12	EXPENDITURES FOR IMPROVEMENTS, INCLUDING NEW BUILDINGS, ADDITIONS, PERMANENT BETTERMENTS, ETC. *(Under this heading should be included all expenditures for items, such as additional land, new buildings, new equipment, etc, which represent not restorations or replacements but additions to plant.)*		
13	EXPENDITURES FOR OTHER PURPOSES *(Specify)*		
14	*TOTAL EXPENDITURES (sum of Items 11, 12, and 13)*		
15	AMOUNT RETURNED TO STATE TREASURER OR OTHER OFFICIALS		
16	BALANCE ON HAND AT CLOSE OF YEAR *(Include balance for maintenance and for all other purposes.)*		
17	*TOTAL DISBURSEMENTS (sum of Items 14, 15, and 16; also equal to Item 6)*		

REPORT FURNISHED BY

DATE　　　SIGNATURE　　　TITLE

Office of Developmental Disabilities Form

Survey of
Public Institutions for the Mentally Retarded

DEFINITIONS

Line 1: RESIDENT PATIENTS AT BEGINNING OF YEAR – Include all patients physically present in the institution at the beginning of the year. Include also those away on vacation who will return after their vacation period. Do not include patients on unauthorized absence (escape, elopement or AWOL), trial visit, family care "otherwise absent."

Line 2: FIRST ADMISSION – Include patients who have not previously been admitted to any public or private inpatient institution for the care or treatment of mental retardation.

Line 3: READMISSIONS – Include patients admitted with a record of previous care as indicated above. Exclude transfers, that is, patients who are moved between institutions within a single state system with no break in custody.

Line 5: DEATHS IN INSTITUTION DURING YEAR – Include only patients who die while resident in the institution. Do not include deaths among patients on leave even though these patients are still on the hospital books.

Line 6: RESIDENT PATIENTS AT END OF YEAR – Include all patients physically present in the institution at the end of the year. Include also those away on vacation who will return after their vacation period. Do not include patients on unauthorized absence (escape, elopement, or AWOL), trial visit, family care or "otherwise absent."

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF HUMAN DEVELOPMENT
Developmental Disabilities Office

SURVEY OF
PUBLIC INSTITUTIONS FOR THE MENTALLY RETARDED

Form Approved
Budget Bureau No. 85-RO-253

NAME AND ADDRESS OF INSTITUTION OR STATE AGENCY THAT IS COMPLETING THIS REPORT

RETURN TO: OFFICE OF HUMAN DEVELOPMENT
DEVELOPMENTAL DISABILITIES OFFICE
330 INDEPENDENCE AVE., S.W.
WASHINGTON, D.C. 20201

FOR CURRENT YEAR ENDING JUNE 30, 197____

ITEM NO.	ITEM	CURRENT YEAR 197____
1	RESIDENT PATIENTS AT BEGINNING OF YEAR	
2	FIRST ADMISSIONS	
3	READMISSIONS *(Exclude transfers)*	
4	TOTAL ADMISSIONS *(Items 2 and 3)*	
5	DEATHS IN FACILITY DURING YEAR	
6	RESIDENT PATIENTS AT END OF YEAR	
7	NET RELEASES DURING YEAR COMPUTE: *(Item 1 + Item 4 – Item 5 – Item 6)*	
8	TOTAL PERSONNEL EMPLOYED FULL TIME AT END OF YEAR *(Do not include patient employees)*	
9	TOTAL MAINTENANCE EXPENDITURES FOR PATIENTS DURING YEAR *(Include all expenditures for operation of the hospital and maintenance of the plant and equipment, including ordinary repairs and replacements)*	
10	AVERAGE DAILY RESIDENT PATIENT POPULATION DURING YEAR	
11	NUMBER OF INSTITUTIONS INCLUDED IN ABOVE FIGURES *(please list each institution included under comments)*	

NOTE: If information for a given item or group of items is not available from final data, please enter your most reliable estimate. Each estimated figure should be followed by "EST.)"

COMMENTS

REPORT FURNISHED BY:	NAME *(Please print)*	OFFICE PHONE	AREA CODE	NUMBER
	TITLE	DATE COMPLETED		

APPENDIX D

Forms from Surveys of Residents in Institutions for the Mentally Retarded in the 1970s

SCHEERENBERGER'S 1976 SCHEDULE

BASIC INFORMATION

Residential Facility No. ______

1. (Check one only)
   - A. Your facility serves mentally retarded persons only: Yes ____ No ____
   - B. Your facility is a unit of a mental hospital: Yes ____ No ____ Other ______________
2. What year did your facility accept its first resident: ______________
3. As of June 30, 1976:
   - A. Rated bed capacity ______________
   - B. Total number of residents ______________
     - Female ______________
     - Male ______________
4. Please list your FY 75-76 population by chronological age and level of retardation as of June 30, 1976:*

Level of Retardation	Chronological Age																								
	<1	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22-41	42-61	62+
Normal+																									
Borderline																									
Mild																									
Moderate																									
Severe																									
Profound																									
Total																									

* FY 75-76 is defined as July 1, 1975 - June 30, 1976.

B. List your returns or readmissions during FY 75-76 according to level of retardation and chronological age (exclude respite admissions):

Level of Retardation	Chronological Age																								
	<1	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22-41	42-61	62+
Normal+																									
Borderline																									
Mild																									
Moderate																									
Severe																									
Profound																									
Total																									

What were the primary reasons for resident returns or readmissions:

1. Lack of adequate community resources ______________ (please specify areas): ______________________________
2. Inadequate follow-up services ______________
3. Failure to adjust to community life ______________
4. Lack of community acceptance ______________
5. Other (specify): ______________________________

5. List your FY 75-76 population according to number of mentally retarded residents with multiply handicapping conditions:

Blind only ____________

Deaf only ____________

Blind and deaf ____________

Emotionally disturbed ____________

Cerebral palsy ____________

Epilepsy ____________

Other physical handicaps ____________

How many have more than one handicapping condition (include deaf and blind): ____________

6. List total number of admissions for respite care during FY 75-76: ______________

ADMISSIONS, READMISSIONS, AND WAITING LISTS

7. Catchment area served:

A. (check one only):

(1) Entire state ____________

(2) Geographical region ____________

(3) Other (specify) ______________________________

Number of square miles ________________

Total population of catchment area ______________________

8. Types of admissions (exclude respite care):

Please check type of admission:	Children	Adults
A. Voluntary	______	______
B. Non-voluntary	______	______
C. Both A and B	______	______

If both A and B, please record percent of admissions for FY 75-76 which were:

	Children	Adults
Voluntary	______	______
Non-voluntary	______	______

9. Admissions FY 75-76:

A. Record new admissions during the fiscal year according to level of retardation and chronological age (exclude respite admissions):

Level of Retardation	Chronological Age																								
	<1	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22-41	42-61	62+
Normal+																									
Borderline																									
Mild																									
Moderate																									
Severe																									
Profound																									
Total																									

10. Do you have a waiting list of retarded individuals approved for admission to your facility: Yes ___ No ___

A. If yes, please indicate: (1) number of retarded persons according to degree of retardation and (2) how many could be managed in community facilities if community facilities were available:

Number on the Waiting List		Number who could be served in the Community Facility	
___	Mild	___	Mild
___	Moderate	___	Moderate
___	Severe	___	Severe
___	Profound	___	Profound
___	Infirm	___	Infirm

B. What is the average length of time on the waiting list: ___

C. What are the primary sources of referrals for admission:

Parents ___
Physician ___
Public schools ___
Social agencies ___
Courts ___
Other (please specify): ___

D. Who determines placement on the waiting list:

Superintendent
Interdisciplinary committee of the facility ___
Interdisciplinary committee not associated with the facility ___
Parents ___
Courts ___
Other (please specify): ___

E. How frequently is your waiting list reviewed: ___

F. Please attach a copy of your admission criteria.

COMMUNITY PLACEMENTS

11. Has your institution population been decreased by community placement over FY 75-76: Yes ___ No ___

If yes, please indicate where these former residents have been placed:

	Number
Own (parental or guardian) home	___
Other relative's home	___
Foster home	___
Group home	___
Community ICF facility (excluding county home)	___
Rest or convalescent home	___
Nursing home	___
Intensive (nursing) care facility (i.e., SNF)	___
Corrections or penal facility	___
County home	___
Hospital for the mentally retarded	___
Work placement (i.e., employee provides 24-hour care)	___
Other (please specify)	___

12. Please list your population for the past five years according to:

	Average Daily Population	Resident Population as of June 30
FY 71-72	___	___
FY 72-73	___	___
FY 73-74	___	___
FY 74-75	___	___
FY 75-76	___	___

13. Given existing community placement resources, how many residents would you estimate will be placed during FY 1976-77:

Categories	Under 18 years	Adult - over 18
Mild	___	___
Moderate	___	___
Severe	___	___
Profound	___	___

14. Prior to community placement, do residents (___), or placement personnel (___), or both (___):

___ Visit community placement
___ Community placement personnel

Does the resident have a voice in selecting the facility? Yes ___ No ___
Parent: Yes ___ No ___

15. Who evaluates and makes determinations concerning community placement:

____ Superintendent
____ Multidisciplinary committee (in-house)
____ Multidisciplinary committee (external)
____ Utilization Review /IPR
____ Parents (excluding return to own home)
____ Other (please specify) ____________

16. A. Upon notification of the intention of community placement, what percent of the parents or guardians voice objections: ____________ percent

B. Following interaction/counseling follow-up with parents or guardians with institute staff, what percent continue to object: __________ percent

C. In those cases where continued parent/guardian objections exist and where your staff judgment maintains the resident should be placed in the community, what do you do:

	children	adults
Retain in institution	____	____
Place	____	____
Other (please specify)		
____________	____	____

D. Are return options available to residents (convalescent/temporary status or discharged) now in community placements:

Convalescent/temporary status ___ No ___ Yes
Discharges/Permanent ___ No ___ Yes

E. Are time limits or other constraints established as conditions for readmission to the institution following community placement?

___ No ___ Yes If yes, please specify ____________

F. Is a formal readmission process required __No ___ Yes
If yes, is court readmission a required process:

GUARDIANSHIP

17. While in the residential facility, who has legal custody of the resident:

	Child	Adult
State	____	____
Superintendent	____	____
Parent	____	____
Other (please specify)		
____________	____	____

18. While in the residential facility, who has legal guardianship of the resident:

	Child	Adult
State	____	____
Superintendent	____	____
Parent	____	____
Other (please specify):		
____________	____	____

COMMUNITY ORIENTED PROGRAMS

19. What direct services do you offer to non-residents from the community:

	Service	Average Daily Attendance
____	Trainable or educable classes	____
____	Self-help or developmental classes	____
____	Personal/social counseling	____
____	Voçational training	____
____	Medical and/or nursing treatment	____
____	Diagnostic services	____
____	Physical therapy	____
____	Recreation	____
____	Sex education	____
____	Home visitation by staff	____
____	Respite care	____
____	Other (specify) ____________	____
____	None	____

RESIDENT PROGRAMS

20. List number of residents enrolled or participating in special programs by level of retardation:

Program	SMR/PMR	Moderate	Mild	Borderline	Total
Formal school or training programs					
Language and speech therapy					
Behavior management					
Work activity, sheltered workshop, vocational trng.					
Formal recreational					
Psychiatric					
Ambulation training					
Toilet training					
Self-feeding					
Individual programs					
Other (specify)					

21. List number of residents in need of special programs but not enrolled:

Level of Retardation	0-2	3-21	22+	62+	Total
Normal+					
Borderline					
Mild					
Moderate					
Severe					
Profound					
Total					

22. How many of your residents participate in off-campus programs sponsored by community agencies:

Program	SMR/PMR	Moderate	Mild	Normal+	Total
Recreational					
Social					
Educational					
Occupational					
Religious					
Volunteers					
Other (specify)					

23. If you operate a work activity or sheltered workshop, are these programs fully certified by the U. S. Department of Labor in accordance with the Fair Labor Standards Act:

Work activity center: Yes___ No___
Sheltered workshop: Yes___ No___

Do you have working residents as defined by the U. S. Department of Labor:

Yes___ No___

How many residents are working for at least minimum wage: ___________
Inside the facility_______________ In the community___________

24. Does each resident have an individually designed program: Yes___ No___

25. Do you have any residents in locked wards (i.e., during the day): Yes___ No___
How many_______________
Why____

26. Are you presently:
A. In full compliance with Title XIX, Section 249.12: ___________
B. In full compliance with Title XIX, Section 249.13: ___________
C. Accredited by JCAH: Yes ___ No ___

27. A. If you are not in full compliance with Title XIX, 249.13, will you be by March 1977 : Yes___ No___

B. If not in compliance, please estimate the cost to attain compliance:
Additional staff ___________
Physical modifications ___________

28. Will you be seeking accreditation by JCAH : Yes ___ No ___

29. Volunteer or extra assistance:
A. How many volunteers served your facility during FY 75-76:___________
Total number of hours served___________

Types of activities:

_______________ _______________
_______________ _______________
_______________ _______________
_______________ _______________

B. How many foster grandparents did you have during FY 75-76: ____________
Total number of hours served ____________

Types of activities:

____________ ____________
____________ ____________
____________ ____________
____________ ____________

PARENTS

30. Please list all programs in which the residents' parents participate (check):

- ____ Treatment
- ____ Recreation
- ____ Training
- ____ Religion
- ____ Sex education
- ____ Public relations
- ____ Fund raising
- ____ Advisory committees
- ____ A. Administration
- ____ B. Program
- ____ C. Advocacy
- ____ Other
- ____ No participation
- ____ No response

31. Approximately what percent of the residents have parental visits at least once a year: ____________

---

32. Staffing: Please indicate present staff and needed staff:

	Presently Budgeted Positions	No. positions filled	Additional Positions Needed
Physicians			
Dentists			
Psychologists			
Social Workers MSW			
Social Workers BA			
Registered Nurses			
Special Educators			
Voc. Therapists			
Rec. Therapists			
Occup. Therapists			
Physical Therapists			
Speech and Hearing Therapists			
Chaplains			
Resident Care Workers (Aides)			
LPN's			
Psychiatrist (Days/Week)			

With regard to additional positions needed, was this projection based on:

Staff judgment ____
ICF regulations ____
JCAH Standards ____
Other (specify) ____

Developmental Disabilities Project 1978 Form

1978 SURVEY OF PUBLIC RESIDENTIAL FACILITIES SERVING THE MENTALLY RETARDED

Address label of state coordinator of mental retardation services pasted here.

Return completed survey to:

Developmental Disabilities Project
Attn: Dr. Krantz
Dept. of Psychoeducational Studies
110 Pattee Hall
University of Minnesota
Minneapolis, MN 55455

INSTRUCTIONS: See cover letter. Please complete and return this brief survey. Do not hold it for final figures; if necessary, use estimates and mark them with "est." Jot down any comments or notes that you think may be helpful.

1. Number of facilities: How many of these facilities or institutions did your state operate during all or part of the fiscal year 1977-78? Use your own definition of what is a separate facility.

   a. facilities, operated by the state, that are exclusively or primarilly residential facilities for the mentally retarded .... ____

   b. facilities operated by the state as mental hospitals or as any other care facilities and which have a significant number of residents whose primary diagnosis is mental retardation. Do not count penal institutions. .... ____

2. Number of residents at beginning of year; How many mentally retarded persons were resident in these facilities on June 30, 1977 (a year ago)? Include those persons who were on trial placement or on vacation or leave, but who were still carried on the facility's roll of residents.

   a. in state residential facilities for the mentally retarded .... ________

   b. in other state residential facilities (see 1.b above), persons whose primary diagnosis was mental retardation .... ________

3. Average daily residents: What was the average daily resident population of mentally retarded persons in these facilities during FY 78 (July 1, 1977 to June 30, 1978)?

   a. in state residential facilities for the mentally retarded .... ________

   b. in other state residential facilities, persons whose primary diagnosis was mental retardation .... ________

4. Number of residents at end of year: How many mentally retarded persons were resident in these facilities on June 30, 1978 (this year)? Include persons who were on trial placement or on vacation or leave, but who were still carried on the facility's roll of residents.

   a. in state residential facilities for the mentally retarded .... ________

   b. in other state residential facilities, persons whose primary diagnosis was mental retardation .... ________

5. First admissions: How many persons with a primary diagnosis of mental retardation, and who had not previously been resident in one of your state-owned facilities serving the mentally retarded, were admitted to these facilities between July 1, 1977 and June 30, 1978?

a. to state residential facilities for the mentally retarded .... ________

b. to other state residential facilities, persons whose primary diagnosis was mental retardation .... ________

6. Re-admissions: How many persons with a primary diagnosis of mental retardation, and who had previously been resident in one of your state-owned facilities serving the mentally retarded, were admitted to these facilities between July 1, 1977 and June 30, 1978? Do not include those who transferred between facilities of these two types.

a. to state residential facilities for the mentally retarded .... ________

b. to other state residential facilities, persons whose primary diagnosis was mental retardation .... ________

7. Live releases: How many persons with a primary diagnosis of mental retardation were officially released from the facilities and removed from the institutions' rolls during the period from 7/1/77 to 6/30/78? Include those who had made the physical move, such as to trial placement, before 7/1/77; do not include those who had made the move during the year but were still "carried on the books" of the facilities on 6/30/78. Do not include transfers between state institutions.

a. from state residential facilities for the mentally retarded ..... ________

b. from other state residential facilities, persons whose primary diagnosis was mental retardation .... ________

8. Deaths in institutions: How many persons with a primary diagnosis of mental retardation died during the period July 1, 1977 to June 30, 1978 while they were residents of these facilities? Include, if possible, those who were on the institutions' rolls at the time of death but who were physically on trial placement or on leave or in community hospitals.

a. in state residential facilities for the mentally retarded ...... ________

b. in other state residential facilities, persons whose primary diagnosis was mental retardation .... ________

9. Per diem: What was the per diem cost of care of residents with a primary diagnosis of mental retardation in these facilities in you state in fiscal year 1977-78?

a. in state residential facilities for the mentally retarded ..... $ _____._____

b. in other state residential facilities, for persons whose primary diagnosis was mental retardation .... $ _____._____