WHAT DOES THE FUTURE HOLD?

FOR the past twenty years researchers have been working as never before to solve the problem of epilepsy. Much of the initial activity was centered in the Department of Neurology of Harvard Medical School, where Drs. Stanley Cobb and William G. Lennox and their associates have attacked the problem along a wide front. The scientific, the medical, the psychological, the social, and the economic aspects of epilepsy are so diverse and so intriguing that many workers in many centers throughout this and other countries are busy, or will be—if financial aid is forthcoming. Investigations carried on in Montreal, Chicago, Minneapolis, Baltimore, Rochester (Minnesota), New York, and Philadelphia have been particularly rewarding.

The scientists and doctors interested in the disorder are banded together in the International League Against Epilepsy, whose American chapter holds annual meetings for the presentation of the latest findings. The League also publishes *Epilepsia,* an annual journal in which all medical writings on the subject of epilepsy and related disorders are listed and reviewed. A recent issue lists the contributions of 589 authors.

Can Epilepsy Be Prevented?

Little thought has been given to prevention because a seizure is almost always a complete surprise to all concerned. Parents say, "We never dreamed that such a thing would happen to our child," and eight out of ten will add, "There has never been a case like this on either side." Prevention of seizures involves eugenics for those who transmit a predisposition and also the elimination of conditions that may lead to seizures in persons born with a tendency to them. Some of these conditions are named on page 7. First, we must know more of the cause of the spontaneous seizure before any plan of eradication of epilepsy is conceivable.

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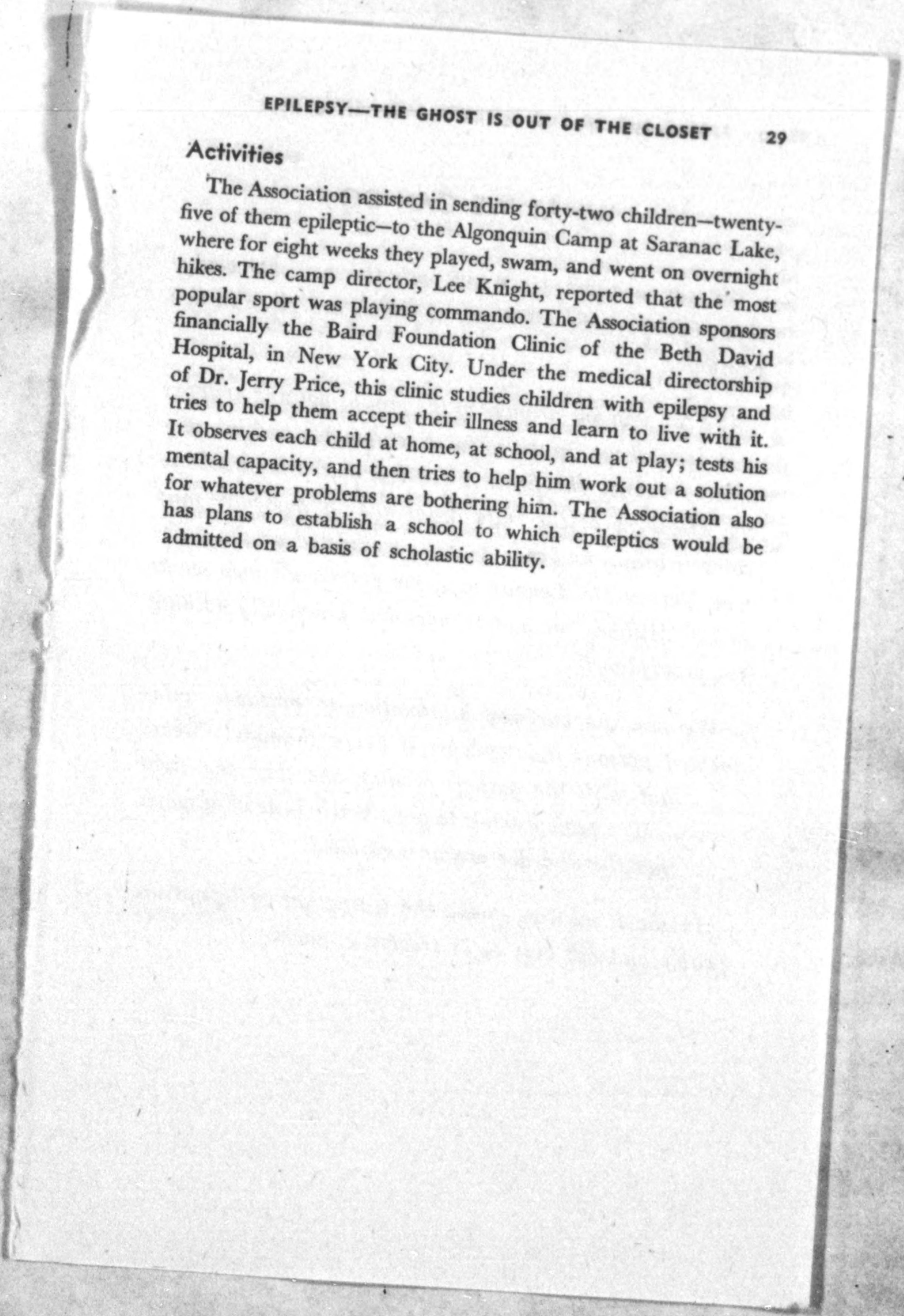
How Laymen Are Helping

The work of research must be done by doctors and other scientists but the money must come largely from laymen. And laymen must be largely responsible for educating the general public.

Two laymen's organizations have been set up to help finance research and to tell the truth about epilepsy. The older of these is the American Epilepsy League, a national organization founded in 1939 as the Laymen's League Against Epilepsy. The main purpose of the League from the beginning has been the education of the public and the encouragement of research. The League now has members in forty-six states and five foreign countries. They pay $1, or $5, or $25 a year and receive in return a copy of *Science and Seizures* by Dr. William G. Lennox or of *Convulsive Seizures* by Dr. Tracy J. Putnam. They also receive bulletins summing up new advances, and the $5 members become subscribers to *Epilepsia*. Life membership is $50.

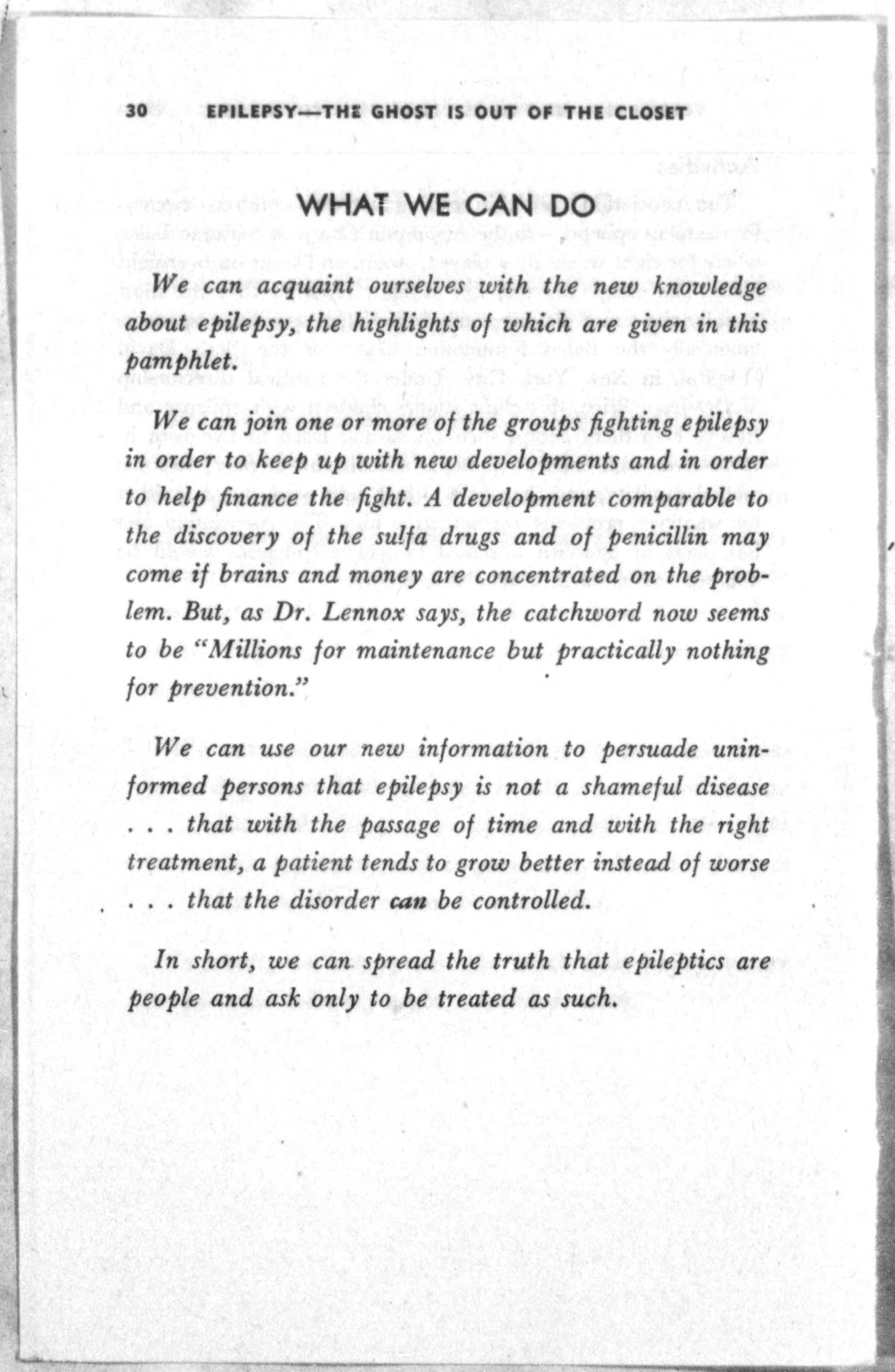
In distributing its informative material outside its membership, the League works through established groups like the United States Employment Service Centers, the social service departments of hospitals, District Nursing Associations, the Red Cross, medical services of the Armed Forces, and rehabilitation agencies. It has a list of doctors who are particularly interested in epilepsy, and a list of clinics, hospitals and other institutions where epileptics may be treated. It has set up an endowment fund to receive funds for research. League headquarters are at Room 405, 50 State Street, Boston. The president is Mrs. Brooks Potter.

The National Association to Control Epilepsy, Inc., chartered by the University of the State of New York, has been established recently with headquarters at 22 East 67th Street, New York City. Through education and research, the Association is building an informed public opinion on the problem. Mrs. Henry H. Denning is Executive Secretary. Annual dues are $1 and $5.



Activities

The Association assisted in sending forty-two children—twenty-five of them epileptic—to the Algonquin Camp at Saranac Lake, where for eight weeks they played, swam, and went on overnight hikes. The camp director, Lee Knight, reported that the most popular sport was playing commando. The Association sponsors financially the Baird Foundation Clinic of the Beth David Hospital, in New York City. Under the medical directorship of Dr. Jerry Price, this clinic studies children with epilepsy and tries to help them accept their illness and learn to live with it. It observes each child at home, at school, and at play; tests his mental capacity, and then tries to help him work out a solution for whatever problems are bothering him. The Association also has plans to establish a school to which epileptics would be admitted on a basis of scholastic ability.



WHAT WE CAN DO

We can acquaint ourselves with the new knowledge about epilepsy, the highlights of which are given in this pamphlet.

We can join one or more of the groups fighting epilepsy in order to keep up with new developments and in order to help finance the fight. A development comparable to the discovery of the sulfa drugs and of penicillin may come if brains and money are concentrated on the problem. But, as Dr. Lennox says, the catchword now seems to be "Millions for maintenance but practically nothing for prevention."

We can use our new information to persuade uninformed persons that epilepsy is not a shameful disease . . . that with the passage of time and with the right treatment, a patient tends to grow better instead of worse . . . that the disorder ***can*** *be controlled.*

In short, we can spread the truth that epileptics are people and ask only to be treated as such.

FOR FURTHER READING

Epilepsia, Journal of the International League Against Epilepsy, Harvard Medical School, Boston, Mass. Published annually. $1.00

Lennox, William G. *Science and Seizures: New Light on Epilepsy and Migraine.* New York, Harper & Brothers. 1941. $2.00

Putnam, Tracy J. *Convulsive Seizures: A Manual for Patients, Their Families and Friends.* Philadelphia, J. B. Lippincott. 1943. $2.00

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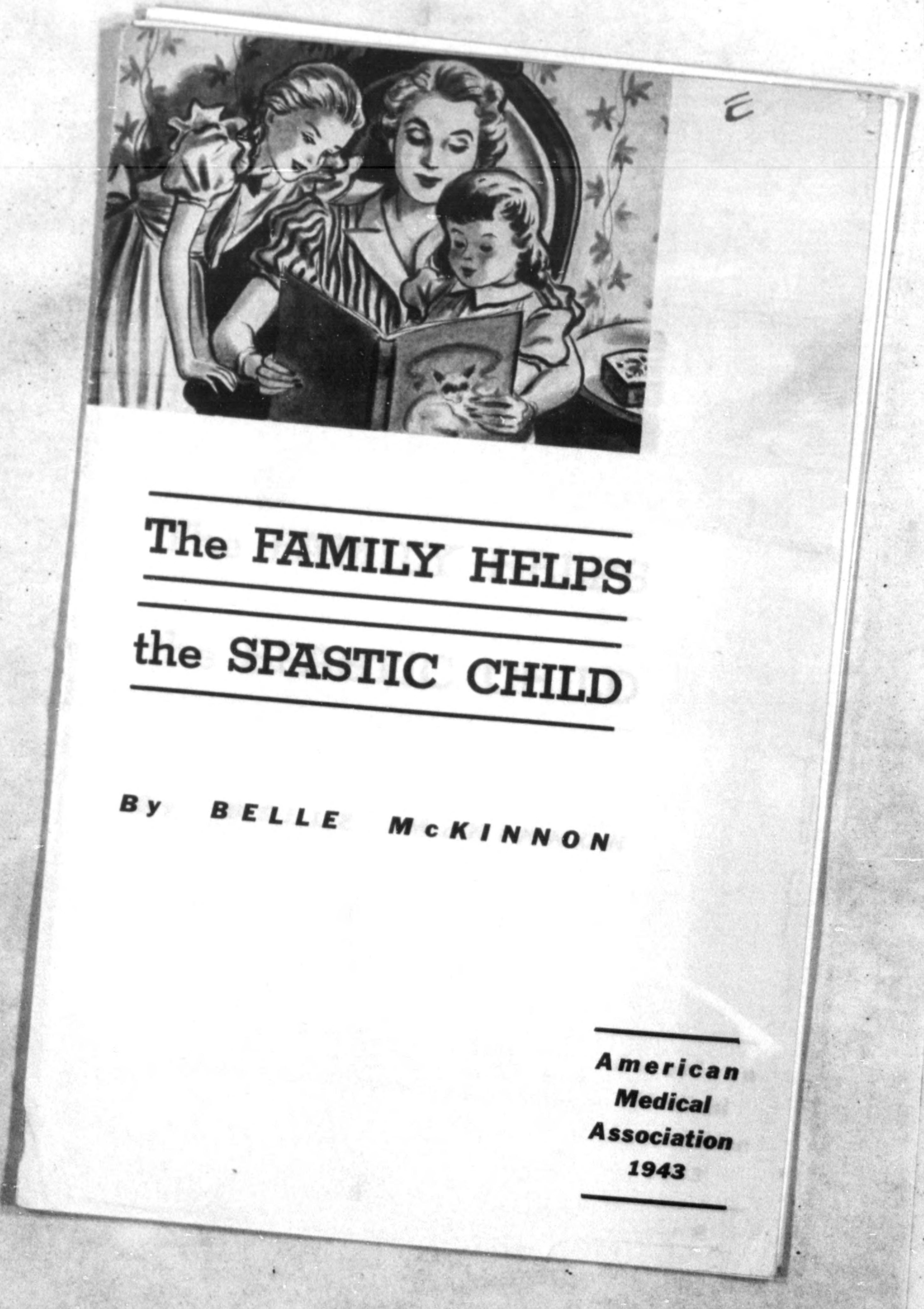

The FAMILY HELPS the SPASTIC CHILD

By BELLE McKINNON

American
Medical
Association
1943

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The FAMILY HELPS the SPASTIC CHILD

ALL was not well. Our baby was not gaining and growing as a newborn baby should do. The tiny hands were always drawn up inside the little sleeves, no matter how often I drew them out. That was the first sign. Then gradually our suspicions became confirmed that our child was going to be handicapped.

At the age the normal baby reaches for a toy or rattle when held out to him, our baby's hands drew back instead. When she did make an effort to grasp a toy, she trembled all over.

The next step in the normal baby's development, that of sitting up alone, found Kay unable to sit erect or hold her head steady. It was even impossible to prop her up with pillows. She fell over constantly, at times striking the back of her head on the floor. We began to think out ways and means to meet the emergencies in each milestone of her life.

Kay was intelligent we knew. She had a happy disposition and tried to greet every one with a smile. It was our desire to raise her as nearly normal as possible.

We padded her high chair, nursery chair and carriage, so the constant jerking of her head would not injure her; it protected her as much as possible from fright. I noticed when placed on a bed or in her carriage, Kay seemed to have a sense of falling: She would grasp at things wildly with her hands. To overcome this and give her confidence, I would place my face against hers and keep it there until she was lying flat. Gradually she seemed to overcome that sensation.

When Kay should have been creeping but could not even sit alone on the floor, my husband bought a small "kiddy-car," made with two wheels in back and one in front. He removed the two back wheels and placed them much wider apart, so the little car could not possibly upset. We placed Kay on this and taught her to grasp the handle bar. She gradually became adept at moving about the house on this car. Kay slowly learned to sit erect on this little car and could then be placed on the floor, where she learned to move about by hunching herself along, first one leg, then the other.

The control of the finer finger movements were extremely difficult. It was almost impossible for her to pick up anything from the floor; so to encourage her to use her hands, a basket of toys was kept on the floor, mostly balls and blocks of different sizes and shapes but without sharp edges. At some time during the day, some member of the family would sit on the floor and play with Kay. All the toys would be dumped on the floor; then Kay would be asked to pick up each article. In this way she learned the names of toys and how to use her hands. Of course, she was very happy in our praise.

The muscles of the back, especially those along the spine, and the legs and arms were gently massaged every day, and warm baths were given every night.

We learned early that it required the greatest of patience and self control to do good work things wildly with her hands. To overcome this and give her confidence, I would place my face against hers and keep it there until she was lying flat. Gradually she seemed to overcome that sensation.

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The muscles of the back, especially those along the spine, and the legs and arms were gently massaged every day, and warm baths were given every night.

We learned early that it required the greatest of patience and self control to do good work with Kay. We learned to discipline her gently, for sharp speech or quick movements seemed to make all her movements "wilder" than usual. She was always close either to tears or laughter, and it took years to teach her to control her emotions and to cultivate poise.

Our other daughter, older by seven years, was a wonderful companion and help to Kay. She disliked having any one speak of Kay as crippled, and through her the little sister was given normal play and recreation; she included her in almost everything she did.

One of the most difficult things for Kay to learn was to feed herself. She was given her own silver and plate. At first she would eat a few bites and then beg me to feed her, as it was a great effort to try to get the food to her mouth. I always helped her finish, for we did not want anything we did for her to become irksome. Then, too, we wanted to be sure she had sufficient food. By doing this at each meal, she learned to handle first a spoon, then a fork and the drinking glass. But all this took months of patient practice.

Kay's right side seemed to be a little worse than the left, so she used her left hand. We did not try to change her but encouraged her to use both hands as much as possible.

Three years passed by, and Kay was unable to stand alone. Never undaunted, we still hoped to do something about the walking. My husband built a sand pile and a play pen for Kay so that she could be out in the air and sunshine as much as possible. Then we bought a baby walker for Kay; although it held her up, there was no control to her movements, and she hit everything in her path. One thing she did learn in this walker was to lift the front up to pass over rugs.

One exercise Kay never tired of was stepping on and off a small stool, while we supported her by holding each hand. She learned from this to lift up her foot instead of drag it. At this time, Kay wore "corset" shoes to support her ankles; but no other braces were ever used on her.

Kay's Daddy came home one day with a surprise, a little tricycle. She was thrilled and to our surprise learned to ride in a short time. Of course she had many "spills," because the least excitement that caused her to turn too short or lose control caused an upset.

Coordination seemed to be developing a little more definitely, and one evening Kay pushed her carriage across the room all by herself! From this time on, she developed an unsteady sort of a walk, staggering and falling often but always getting up on her feet again.

Swimming classes twice a week and vacations spent near water showed so much improvement that we built a small swimming pool in the backyard at home.

The cement pool, oblong in shape with rounded corners, was 24 feet long, 8 feet wide and a possible depth of 5 feet. Half of the pool was below the surface, and the dirt excavated was used to bank the walls; the family gathered rocks and planted shrubs to make it ornamental as well as beneficial. It was enjoyed by all members of the family. Kay spent hours each day learning to swim, and the pool was shared with her friends, thus providing the companionship of children her own age.

Hand and finger exercises were being encouraged, too. A blackboard and chalk were found did learn in this walker was to lift the front up to pass over rugs.

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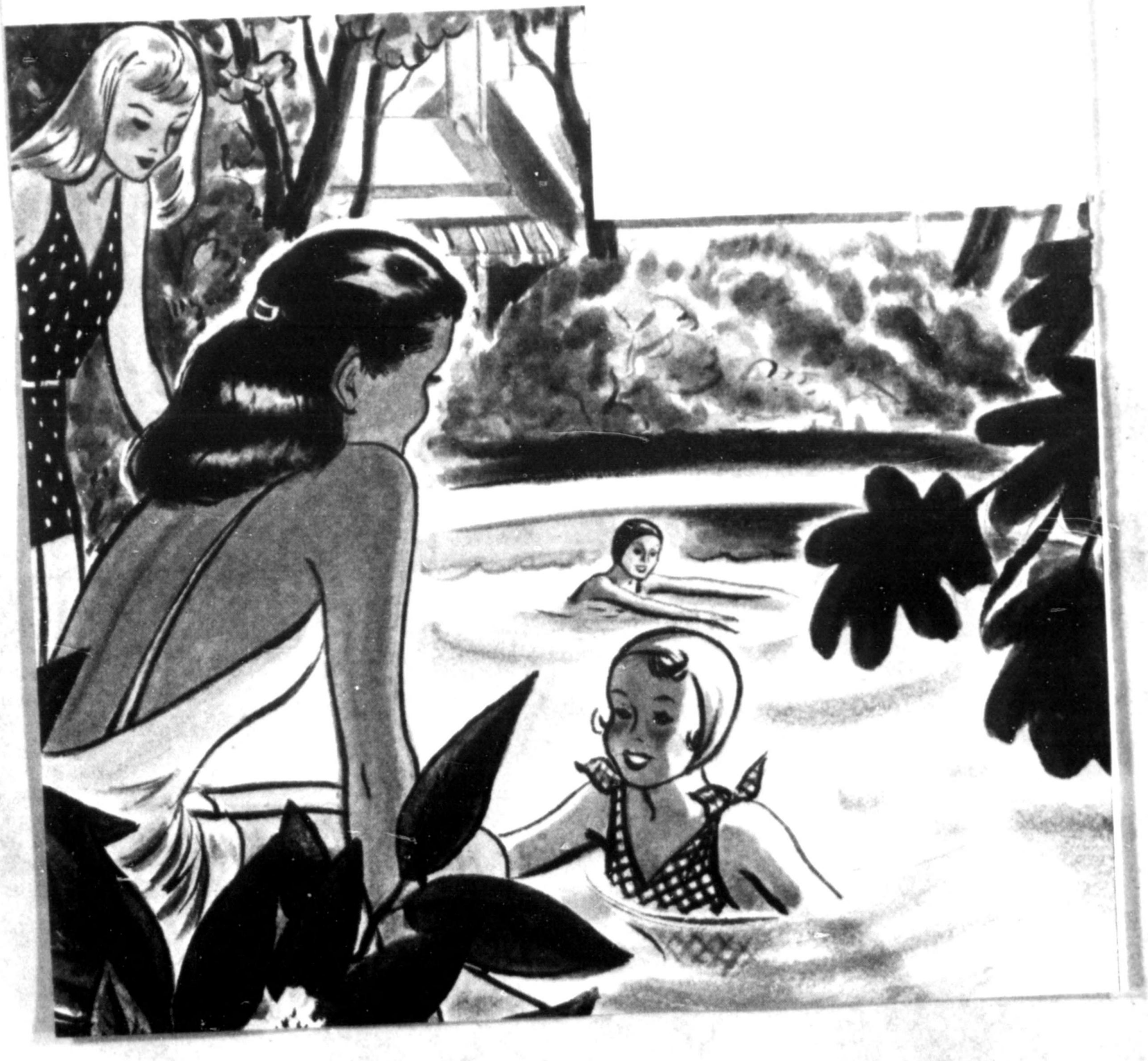
Exercise was all important in Kay's regimen. She learned the use of her muscles first by such tricks as stepping on and off a stool. Then we built a swimming pool in the backyard, which not only stimulated her muscles but brought many new friends.

helpful, as were colored blocks for building and wooden peg games. Marbles also afforded excellent opportunities for finger exercise. Noting Kay's keen interest in games, she was taught to play fair, to be a good loser and never take advantage of her handicap to win or have her own way.

When a normal child becomes tired, he usually relaxes and rests. Just the opposite was true of Kay. When she became weary, both nerves and muscles ran wild, and we found



the most effective means of quieting her was to read aloud from her favorite books.

We were happy in the progress Kay was making; she was gaining in health, growing taller, and though she was unable to dress herself, she was learning to lace her shoes. Kay's speech had not improved a great deal, although the family could understand her. Actually she had a good vocabulary and a retentive mind. She was by now attending Sunday school with her sister.

When Kay was 6 years old, the kindergarten teacher, being sympathetic and considerate, was willing to assume the responsibility of having Kay in her class. There was no other school except the public school, which was about two blocks from our home. Kay was unable to walk this distance but could ride her tricycle, and I took her to school and called for her when she was ready to come home.

We did not know how the other children would accept her but found them kind and helpful in doing little things she was unable to do for herself. We found ways for Kay to repay them. The school served milk in midmorning to underweight children, and each week Kay paid for some child who could not otherwise afford it. About once a month a movie was shown for the grade pupils, and there were always some who had no money for a ticket. Kay furnished a ticket, and the teacher had her choose the child who was to use it. The lesson she learned from this was to give as well as accept help from the other children.

Progress was highly satisfactory in this school. The teachers were interested in Kay, and each gave her as much individual attention as possible in a crowded public school. It was impossible for her to hold either her book or her head steady, so her lessons had to be read to her. When the teacher couldn't do this, she asked a pupil to read for her. Kay learned to cut and paste. Although she usually tore her paper by pressing too hard on her pencil, she could print some words and, strangely enough, make good numerals.

Out in the playground it was more difficult, because Kay was apt to fall at any time and thus interfere with the games. So she was left to stand on the sidelines with her little arms folded, a means she had found to give her balance. We hit upon a plan of giving her a little lunch to take to school every day in a paper bag. Since she shared this with the other children on the playground, they learned to look forward to it. This gave Kay a feeling of importance, greatly necessary at this time. She was included more and more in the games and learned to play some of them successfully.

To look down from the top of any stairs caused a tenseness and fear that Kay could not control. To overcome this, we had a six sided rack constructed 10 feet high. It was on the order of a building frame, made of two-by-four planks firmly nailed from one post to another in an irregular manner. This offered a tempting place to climb. After being warned to be careful not to get hurt, permission was granted. The second day Kay could climb about two feet off the ground, and within two weeks she could climb without fear all the way to the top. The rack was then torn down, after having served its purpose.

In school, Kay passed along from grade to grade with the same group of children. Later she was transferred to a larger school along with this group. Here she became a little more self conscious, for the strange children often said unkind things and were apt to make fun of her awkward movements. Again the swimming pool played an important role, because after learning Kay had a pool, she became much sought after. Out of the group who wanted to swim, she gained some sincere friends and companions.

At the critical adolescent age, business reasons made it necessary to move from the town where Kay had lived all her life to a large city. We were thankful her social adjustment had been carefully constructed up to this stage. Because of her handicap, Kay was required to take an intelligence test in order to enter the public school. She passed this beautifully and was placed in one of the large grade schools where she had to compete with the physically fit youngsters and where there was not much chance of individual help from her teachers. But Kay was not happy.

The few young friends she knew lived some distance away, and there were no girls in the neighborhood. Kay was lonely. The neighborhood boys were thoughtless and unkind. They would mimic her speech and make fun of her movements. She dreaded to go outdoors.

Kay was now 13 years old, with a well developed body, unusually strong and muscular for a girl. This was probably due to her well balanced diet and the physical training she had been receiving all these years.

Careful consideration of this situation for some time offered no solution. Then my husband brought home a pair of boxing gloves and started to show Kay how to use them. Balance and how to hit with the elbows held in was the means of controlling wild swings. Kay's spastic muscles gave her a vicious punch, somewhat like a spring released.

After Kay learned to take a punch as well as give one, her father gave her these instructions: "You can now protect yourself. And the next time that you are annoyed by a group of boys, walk right into the crowd, choose the largest boy in the group, don't lose your temper, watch your balance and arms, and let him have it. Be sure that one punch does it. Smile at the rest of the crowd, and walk on. Your troubles along that line will then be over."

Two days later that very thing happened in the city park when Kay was returning home from school. After two such skirmishes, she gained the respect of the whole gang. Later they invited her into their stamp club, where she was the only girl member, and from this episode grew an interesting and educational hobby for Kay. She still collects stamps and has made many contacts and adult friends through this interest.

Kay had a typewriter but had never used it much; now, however, she was becoming more interested in it and would pick out a few words occasionally. My husband took a board about 30 inches long and 10 inches wide. He bored round holes about 3 inches apart in the board and placed letters above each hole in the same relative position as those on the typewriter key board. Pegs with tops of different sizes and shapes were used to spell out words, using first one peg then another to plug in the proper letter. This taught the position of the letters on the typewriter; the length of the board gave arm movement, and the different shaped peg tops necessitated finger movement according to the shape of the peg.

To give Kay more reeducation of her muscles, we took her out of school for a term and sent her to a physical training school. Her individual instruction located and corrected some faults. For instance, she had been riding a bicycle for years, but when she tried a stationary bicycle and was told to pedal backwards, it was difficult for her to get into reverse.

Kay's self confidence was being built up during this time, too. For her physical education she went to an adjacent city alone on the street car. This gave her a chance to make decisions for herself and meet competently new situations. She often visited the art gallery alone and would fall in with some group who was being shown through; and in this way learned about some of the things she was interested in.

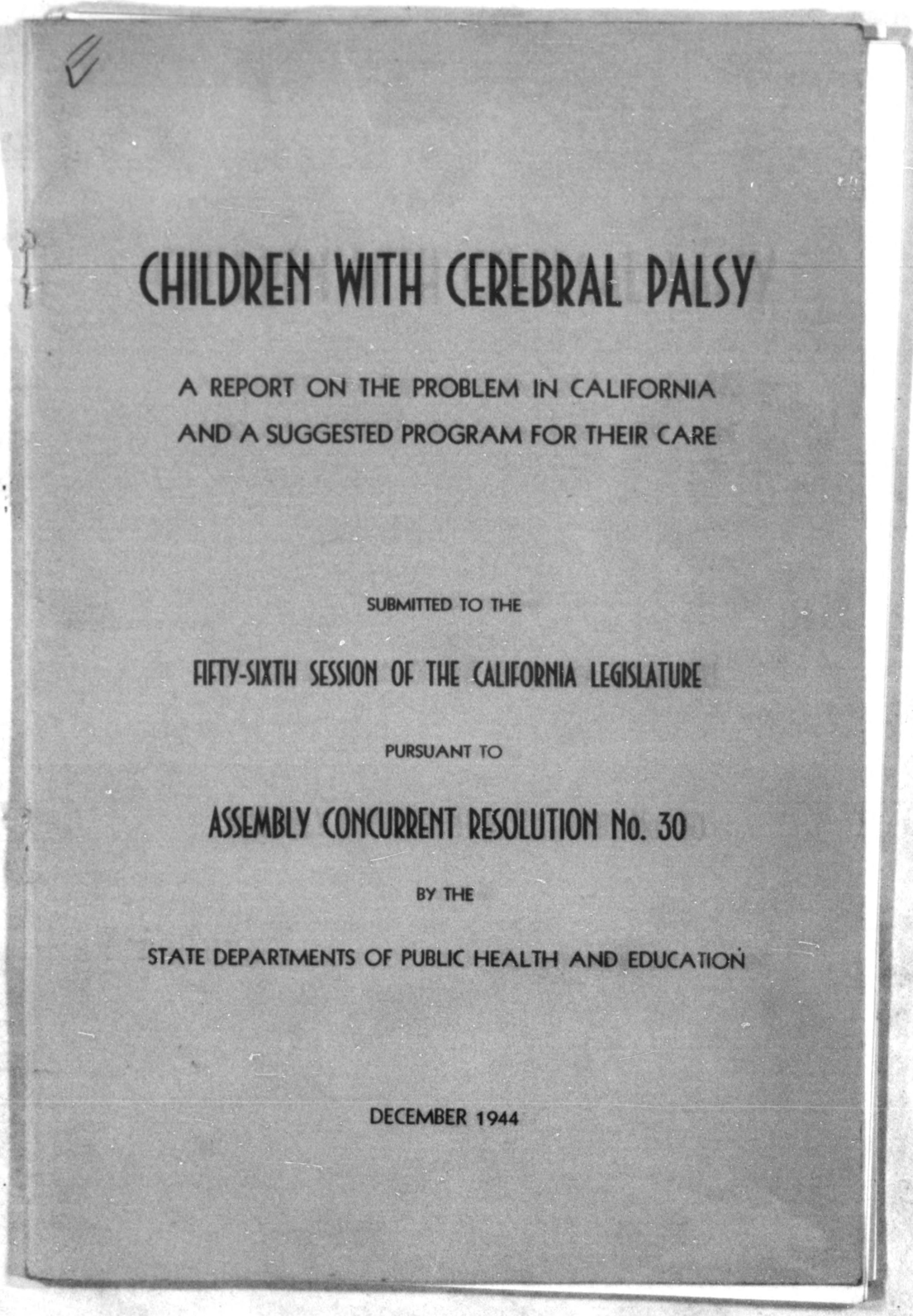
Kay's stride was too long, and she walked with her feet too far apart, which was causing some of the ungainliness. To correct this, my husband took a long strip of linoleum and drew Kay's footprints the proper distance apart and in more of a straight line, which made a more graceful walk. Kay practiced walking back and forth on this pattern and improved her walking greatly.

By constant work and effort and methods that any parent can use in the home, we have developed Kay into a nice looking young woman. She is developing more poise all the time, has a strong healthy body and fits nicely into the world about her; she desires to continue her education in some college.

It is strange how people who would never think of laughing at a blind child or another cripple will stare and make remarks and even laugh at the spastic child. Kay built up a wonderful resistance to this and learned to go along the street with head held erect and to ignore all unpleasantness.

In all our work with Kay we tried to preserve her natural happy disposition. We did not want her to become too mechanical, so she was encouraged to cultivate hobbies in which she would have a happy outlet for her individual desires. Kay is especially fond of dogs and has a Boston terrier besides hundreds of china dogs of all breeds, sizes and colors. Her stamp collection is extremely interesting to her, and she has a rock collection with many unusual specimens. She has had all sorts of pets, from gold fish to a crow named "Jim." She still loves games and plays a good game of chess. Recently she has been playing "Pick Up Sticks" and Chinese Checkers, which are especially helpful for finger muscles.

We feel Kay is now living a full normal life for one who started out nineteen years ago almost a helpless cripple, and we should like to say to the parents of a spastic child, "Don't give up! Give the little fellow a chance!"



CHILDREN WITH CEREBRAL PALSY

A REPORT ON THE PROBLEM IN CALIFORNIA
AND A SUGGESTED PROGRAM FOR THEIR CARE

SUBMITTED TO THE

FIFTY-SIXTH SESSION OF THE CALIFORNIA LEGISLATURE

PURSUANT TO

ASSEMBLY CONCURRENT RESOLUTION No. 30

BY THE

STATE DEPARTMENTS OF PUBLIC HEALTH AND EDUCATION

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CHILDREN WITH CEREBRAL PALSY

REPORT ON THE PROBLEM IN CALIFORNIA AND A SUGGESTED PROGRAM FOR THEIR CARE

Of all handicapped children, those afflicted with cerebral palsy are the most neglected, the least understood and in the greatest need of attention in California at this time. The purpose of this report is to indicate the nature and extent of the problem, to show that present facilities are woefully inadequate and to recommend a reasonable statewide program of care and education for these children.

On April 23, 1943, the California State Legislature passed the following resolution:

WHEREAS, It is the desire of the Legislature to provide in every way possible for the treatment and education of spastic and crippled children within the State; and

WHEREAS, It is necessary in making such provision that the Legislature be fully informed on the problems relating to the treatment and education of such children; now, therefore, be it

Resolved by the Assembly of the State of California, the Senate thereof concurring, That the Department of Public Health is hereby requested and directed to investigate the problem of spastic and crippled children, having particular reference to the number of such children in the State who are in need of and can be benefited by special treatment or education; and be it further

Resolved, That the Department of Education cooperate in making the investigation, and that each department be given full access to the findings of the other, and that each department report to the Fifty-sixth Session of the Legislature the result of its investigation and make recommendations as to the treatment and education of such children, together with the facilities required for such purposes and the costs thereof; and be it further

Resolved, That the Governor and the State Planning Board be requested to include a study of such as a part of the postwar planning; and be it further

Resolved, That the Chief Clerk of the Assembly shall transmit copies of this resolution to the Governor, to the Department of Public Health, to the Department of Education, and the State Planning Board.

What Is Cerebral Palsy[1]

Cerebral palsy, popularly but erroneously called spastic paralysis, is a condition in which muscular control is impaired or lost. The disability may be severe or very mild; many muscles or groups of muscles may be affected, or only a few, or a single group. The lack of control may be in the arms, legs, tongue, speech mechanism, eyes, or it may

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[1] Adapted from ***Children with Cerebral Palsy***, Illinois Commission for Handicapped Children, June 1943.

affect the hearing. The extent of the disability varies widely and may affect the entire range of normal muscular activity.

Most cases of cerebral palsy are caused by injury to the brain during birth or by faulty development of the brain. Injury or disease during the first years of life may also produce the condition. Such diseases as encephalitis or meningitis may result in cerebral palsy by producing scar tissue in the brain.

The damage which has been done to the brain tissue by injury, mal-development, or disease can not be repaired, but it is possible to retrain the patient in the use and control of affected muscles. Each case requires intensive diagnostic investigation which will disclose the extent of the disability, the muscles affected, and the mental capacity or potentiality of the patient.

Loss of muscular control in cerebral palsy has been likened to the situation which would exist in a telephone switchboard if the electrical impulses traveling in the wires were to be uncontrolled because the insulation had been worn through. In such a case if a plug were to be inserted in the switchboard, instead of one phone ringing or one light flashing, there would probably be many phones ringing continuously and many lights flashing. In a somewhat analogous manner, the impulses which the brain of the cerebral palsied person sends to his muscles are uncontrolled and may result in exaggerated movement, a variety of undesired movements, or no movement at all.

Determining the mental capacity of children with cerebral palsy requires special skill and experience. Cerebral palsied children have been incorrectly judged as feeble-minded in many instances because of facial grimaces, drooling, lack of coordinated speech, partial visual or hearing losses, and a multitude of similar conditions so often present in such cases. For many years feeble-mindedness was believed to be characteristic of cerebral palsy, but it has been definitely shown in recent years that about 75 per cent of the children with cerebral palsy have intelligence quotients of 70 or higher, which indicates that most of them are unquestionably teachable.[2] Many of these children are of superior mental capacity.

There are three main types of cerebral palsy: (1) spasticity, (2) athetosis, and (3) ataxia. These conditions may exist in the same case, but cerebral palsy patients can generally be characterized by one of the three conditions, depending upon which one is the predominating reaction.

"Spastic paralysis" has been used incorrectly as though it were synonymous with "cerebral palsy." Spasticity is only one of the three forms which cerebral palsy may take. Spastic muscles are hypersensitive to stimulation, and when either voluntary or involuntary muscle movements are attempted, the spastic muscle which is in opposition to the muscle being contracted, itself contracts instead of remaining idle or relaxing as it should. This disorder causes even the slightest movement of the spastic muscle to result in exaggerated activity.

In the second group, the athetoid, there are constant involuntary movements of the affected muscles. Emotional states such as fear and anger increase the nervous tension of the patient and cause corresponding increases in the athetoid movements. Usually athetosis is accom-

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[2] *The Farthest Corner*, National Society for Crippled Children, 1944.

panied by a constant tension of the muscles which is apparently caused by an effort to control the athetoid movements. This tension may exist for so long that patients can release it only after prolonged training.

The third general type of impaired muscular control in cerebral palsy is ataxia. This condition, which is due to the inability of the patient to select the proper force to cause a muscle to contract, results in a disturbance of the ability to retain balance and to hold the posture. Ataxia occurs less frequently than spasticity and athetosis but is fairly common.

Treatment of cerebral palsy is a long and difficult process invariably involving far more than surgery. There may be a group of handicaps instead of a single disability. Motor handicaps and sensory disturbances, such as impaired hearing and vision, may be present in the same individual.

In addition to the physical factors inherent in cerebral palsy, there are many secondary factors which have important bearing upon the adjustment of the handicapped child to his family and community, and upon the family and community acceptance of the child. Some of these factors are the frequently present facial grimaces and drooling, the awkward speech, the need for confidence, the inability to relax tensed muscles, and the awkward or stumbling gait of many cerebral palsied children. These factors may cause the family and community to reject the child. The family may become embittered and may even, in extreme cases, hide the child. Parents or friends may be unduly fearful of the child's welfare and become over-indulgent, thus preventing him from achieving an adjustment.

In summary, the needs of the cerebral palsied child include all of those of a normal child plus additional training in learing how to supply his own particular needs. The problem has many facets—the medical, the psychological, the educational, and the social. All of these factors are interactive and each child requires balanced attention to all, often concurrently.

What Can Be Done for These Children

Knowledge and skill in the diagnosis and treatment of the cerebral palsied has increased rapidly during the last 15 years. Despite the fact that the damage done to the brain itself can not be repaired, there is much which can be done for these handicapped children. There is perhaps no other group for whom rehabilitation to even a slight degree makes so much difference and is so important. The range of possibility for physical improvement of these children is extremely wide. As a result of treatment and a coordinated program of education and re-education, some may at best be able to feed and dress themselves; some may, in addition, be able to carry on some work even though they are homebound; others may benefit from training to the point where they can get around the community by themselves and be employed; still others may be rehabilitated to such a degree that they can be completely independent individuals, carrying on a normal life and participating in activities that might be expected of anyone.

This last achievement is of course the optimum and is what one would wish for every cerebral palsied child—as well as for every other child—but the importance of achievement to a lesser extent should not be underestimated. It is of great value to the individual, his family, and the community for the child to be able at least to feed and clothe himself and to be able to move about. Even this limited degree of independence is a tremendous advance over lying helpless in bed, wholly dependent upon the services of others.

Not every child with cerebral palsy is able to benefit from intensive care; neither does every one of them require such care. Only by skilled diagnosis can the extent of damage and the prognosis be judged. One of the most important phases of diagnosis is that which saves the child from being unjustly considered feeble-minded. This happened all too often in earlier days and still occurs too frequently. There are data available which point out the proportion of severely physically handicapped cases who have sufficient mental ability to profit from physical rehabilitation and education. There are also diagnostic procedures available which assist in determining which children may be benefited by present techniques for their care and education. The common belief (which is *not* based on evidence) that children afflicted with cerebral palsy are mentally deficient is probably responsible for the failure in development of adequate facilities for the care and education of these children.

There is no consistent and precise relationship between the apparent degree of the handicap and the possible results to be obtained through treatment. Many of the cases appearing most severe have responded out of all proportion to their apparent promise. Since more than 70 per cent of all cases are of mild or moderate severity and since most of these have intelligence quotients of 70 or above, it is clear that considerably more than half of all cerebral palsied children can be expected to profit materially from a thorough program of care and treatment. The fact that many of the more severely handicapped cases can also profit to some extent by rehabilitation thoroughly justifies the expense and time of treatment.

Number of Cerebral Palsied Children in California

There are between 8,000 and 10,000 persons under 21 years of age with cerebral palsy in California according to conservative estimate. Because of the nature of the condition and the inadequate provisions for diagnosis, care, training, and education of cerebral palsied children, many cases remain unregistered. At the present time, only 1,426 are known to the Crippled Childrens Services of the State Department of Public Health. It has been found through intensive local surveys in other States that there are about six persons per 100,000 total population for each age group and that there is no important variation according to locality. Furthermore, there are no essential differences in incidence by race or according to residence in rural or urban areas. The figure six per 100,000 population has been arrived at from the fact that there is an annual increment of seven per 100,000 population and about one death occurs among these seven before they reach the age of six.[3] During later childhood and adolescence, the death rate of cerebral palsied children, like that of normal children, is low. Upon these factors the

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[3] Phelps, W. M.: Recent Trends in Cerebral Palsy. *Archives of Physical Therapy* 23 (6): 332 (June) 1942.

assumption is made that the greater numbers in the lower age groups counterbalance the smaller numbers in the older groups.

Of the estimated 8,000 to 10,000 afflicted children, about 75 per cent are teachable. As many as 2,000 to 2,500 are candidates for custodial care.

In addition to the children themselves, cerebral palsy has serious effects on the families of which the children are a part. Oftentimes in attempting to meet the needs of the handicapped child, the expense is so great that all members of the family have greater financial burdens than they can bear. Assuming that the families in which there is a case of cerebral palsy are of the same average size as that for California as a whole (3.2 persons per family according to the 1940 census), there are no less than 25,000 to 30,000 persons directly affected by some of the problems associated with cerebral palsy.

Typical Cases

In order to determine as accurately as possible the unmet needs of cerebral palsied children in the State, a questionnaire was sent to the parents of 1,632 persons with cerebral palsy. The names were obtained from the register of the Crippled Children Services of the State Department of Public Health, plus additional names known to the Spastic Children's Society of Alameda, that of Los Angeles, and to the California Society for Crippled Children.

Replies from 426 parents of persons under 21 years old indicate that children under age five tend to remain unregistered and that most of them are not receiving the muscle training and special care which are so urgently needed by preschool children. The special problems of these younger children will be discussed further below.

According to the reports of the parents, the types and extent of handicaps vary widely. About one-half require assistance in feeding, less than half speak well, and one-fourth do not walk at all, while one-fifth require assistance in walking. Sensory impairments are less common than motor handicaps among this group of cerebral palsied children but nevertheless occur frequently. Vision is impaired in one-fifth, hearing in about one-twentieth. Far more significant in revealing the difficulties with which these children and their parents have to cope, is that many of them suffer from multiple handicaps, such as inability to use their hands or to walk, impaired hearing as well as crippled hands, defective vision or speech.

The human side of the problems of cerebral palsied children and of their parents, their teachers and their friends is far more vividly shown by the letters written to the Crippled Children Services in response to the questionnaires. The overwhelming majority of the parents wanted to keep their children with them, even though the physical burden to the mother is in many instances enough to severely encroach on her other homemaking duties. However, practically all parents expressed the great need for special treatment and educational facilities for their children.

A few families who could afford to do so have taken their children to one of the centers in the east. A very small number have been able to take advantage of one of the very few institutions in this State accepting these children. But the majority have sought such facilities in vain.

As illustrations of the frustrations met by parents of spastic children who are vainly seeking both medical and educational opportunities for their children, there are quoted below some of the replies received in answer to the questionnaires sent in connection with this survey. They also serve to illustrate the frame of mind that is reached by parents who find themselves blocked at every turn in their search for assistance. The children's names are disguised, but the situation and the parents' remarks are reproduced accurately. Many of the messages from the parents of these children show great optimism in spite of the frustrations they have met in their search for treatment and education of their children. Some of these are children whose handicap is such that while their normal activities and participation in social groups are hampered, they nevertheless have shown some ability for partial achievements—have been "living on the fringes," as it were. Their parents have been tantalized by the progress their children have made under the limited facilities available. They are only too cognizant of the now unfulfilled potentialities that would blossom forth under the proper training and guidance.

Joe is 14 years old. He has fair use of his hands and has been walking and talking for the last few years, and improving right along. Joe is not attending school now. He attended a public school from February to June last year, but was not allowed to return this year because the principal felt he had not made sufficient progress. Joe's mother says, "I felt they never gave him a fair chance because four months was not a long enough time for a child who had never been in school before * * * I feel he should have some schooling and be among other children."

Hugo is 11 years old. He has good use of his hands and walks unaided, although he has some difficulty with his balance. He speaks fairly well now. Hugo's mother reports, "My child has made a remarkable recovery due to the fine help I was able to secure for him. Our expenses were very heavy for many years and it is only the past year that we have been able to reduce them. At one time and for several years, the therapy was costing us $80 a month * * * *"

Another family has a 12-year-old daughter who is moderately handicapped and who has been attending the public schools. Her father states, "I feel that if there were a center which understood and specialized in the needs of the spastic child, a great step toward complete rehabilitation of these children as useful citizens would be accomplished. I am especially interested in a school of speech training and also physiotherapy treatments, as ____________ County lacks adequate facilities to accomplish much in this particular field."

Another parent of an 18-year-old girl—"I would give my interest in Heil to have her walk in some fashion. I have done all I could as far as my finances would permit without breaking me, and never had the assurance of her walking. So my judgment was, better not spend all and not walk * * * I will not place her in an institution as she is too lovely a child * * * to bury alive. These children need assistance more than any other types of afflicted * * * they have been put out in the barn so to speak.” In reference to the Flack case, “ * * * the public are starving these same innocent children's minds and bodies by not recognizing their needs due to no fault of their parents. There should be two schools and training centers for these children in the State, one in the north and the other in the south near large towns.” The letter continues, recommending provision of temporary residence facilities for the parents, so they could participate in the educational program for the purpose of continuing it at home.

Further samples are given of replies to the questionnaire, setting forth the need for and the desire to participate in any program which may be developed.

“I believe we should have schools for handicapped children in all towns of any size, especially schools for the education and speech training of these children. I know of a good many children in a town of over 100,000 people, and we have no school for these children. No child can get an education with only one-half hour a day from the visiting teacher. They should have at least one-half a day. It could be handled by the public schools. There is a great need for such.”

“Our child has come a long way and each year has brought added accomplishments. Like all parents of spastic children, we want to see everything possible done for these children. Like the blind, etc., they are with us as crosses from heaven and we should carry them with Christian charity. It is just another work of mercy that in the past has been shelved and kept in the background * * * I do think it is time to recognize this worthy cause, which has always been in our midst * * *”

The following are examples of cases where adequate custodial care is the only answer. It is urgently needed in order to relieve the parents from the burden of caring for these children and to permit them to turn their efforts to other children in the family. A program of custodial care which focuses on the particular needs of these children and is instituted in their early years could afford sufficient training to develop to the full their very limited capacities so they at least could tend to their more rudimentary needs.

Many of these bear a significant resemblance to a letter written to a private institution by Mrs. Louise Flack in her search for facilities for the care of her child and introduced as evidence by the defense at her trial for the “murder” of her 8-year-old spastic daughter. This was the much publicized case of a previously devoted mother who broke under the strain of caring for her completely invalided and mentally retarded daughter. Her neglect of the child led to its ultimate starvation and death. Her letter, written a year to the day before the child's death in December 1943, read in part as follows:

“I am very much interested in finding a school or home for her (daughter) where she could receive good care in every way and what educational training she could receive and learn * * *

"I have been told by doctors that it is the best and only thing to do. It breaks my heart to think of not having her with me, but if it is for her good I try to tell myself it is what I must do * * *"

Ellen is 11 years old. She has poor use of both hands and can not walk. She speaks well if not too excited. Her family has found it necessary to go as far as West Virginia to find satisfactory facilities for Ellen, and are incurring monthly bills for her care, which are a constant drain on their resources. Her mother, who lives in a northern county, says, "I am sure that only the mother of a spastic would know how much it would mean to have a desirable place for her child, with the hope that some improvement could be made. I looked for a good many years to find a place where Ellen could receive the proper training, but could find nothing in California. Of course our main idea and hope is to have her near us, as West Virginia is too far away. The costs are great and I work in order to help my husband keep her there. We have not been able to see her for two years now."

Johnny is 13 years old. He is badly paralyzed on one side. His mother states, "Crippled children do better away from home, because at home they learn to depend very much on having things done for them. Away from home they try to learn to do things for themselves. As I am a mother of ten more children besides Johnny, I don't have very much time to give him for his exercises * * * He needs more attention than I can give."

Jacky is 5 years old. He has poor use of both hands, needing complete assistance in feeding. He does not speak, but makes noises like a young infant. He can not walk, but stands on his toes with aid. His parents state that he is so helpless they have been unable to find a school that would take him. "Spastics seem to be children considered unworthy of attention and care, and really they need more care since most of them are so badly handicapped. Because of mother love, or whatever it is, it is hard for parents to be strict and unyielding where their children are concerned."

Eddie is 5 years old. He has fair use of his hands and can feed himself, although he is awkward about it. He can speak single sentences now, but only his family can understand him. He does not walk and is unable to stand alone. He has been examined by several doctors but has never been hospitalized. He has only received home treatment. His mother would like to find a wheelchair for him "as he now lies in bed all day long or has to be carried around by an adult."

Helen is 10 years old. She has fair use of her hands but can not walk. She speaks well and her mother says she has a high I. Q. However, she can not go to school because she can not walk and there is no available transportation. Her mother feels that "* * * a proper school with systematic muscle training would give her more than an even chance for a happier future. Having three other children I don't feel sufficiently capable of helping her enough myself. A proper custodial home would be the answer to every dream any parent of a spastic child could ask for."

The above illustrations are only a sample of scores of similar cases reported to the Crippled Children Services in response to its survey. These are the cases of the more severely handicapped children who all their lives will need constant care for even their ordinary daily wants.

Present Facilities for Treatment and Care As They Now Exist

Adequate provision for the treatment and care of cerebral palsied children requires specialized diagnostic facilities, followed sometimes by surgery, and usually by prolonged physical, occupational, and speech therapy. In order to determine what facilities are available in California, an inquiry was made by the Crippled Children Services of the State Department of Public Health to hospitals, convalescent homes, and other institutions which might offer some help to these children.

Of the 370 hospitals which take children, only one reported facilities for meeting the needs of cerebral palsied children in a coordinated program of surgery, physical therapy, speech training and occupational therapy, combined with an academic program. Six hospitals reported facilities which include some elements in a coordinated program, and eight hospitals reported physical therapy facilities available for such children. Several of these hospitals also provide orthopedic surgery for cerebral palsied as well as other crippled children. A number of the hospitals indicated above, stated that although they had physical therapy departments and accepted cerebral palsy patients, they did not feel that their physical therapists were equipped to give the specialized treatment needed by cerebral palsied patients. A total of 98 children, out of the estimated 10,000 in the State, were reported to have received some type of care during the first 10 months of 1944. The hospital in which the type of coordinated program referred to above is functioning, is East Bay Children's Hospital in Oakland. The cerebral palsy unit includes muscle training, speech training, academic education, and adjustment to group living. This program has been in effect since 1939. The hospital-school came into existence through the efforts of the Alameda Spastic Children's Society, an organization composed of parents and friends of spastic children. The Cottage School, as it is called, is operated by the Oakland public schools on the hospital grounds, providing a coordinated treatment and educational program for 14 preschool children between the ages of three and six years. The average length of attendance in the hospital-school is from one to three years. Admission to the school is possible only after a complete medical, neurological and orthopedic examination in the hospital. Daily physical therapy is provided by the hosptal at rates within the parents' capacity to pay. Individual specialized training is provided by the Oakland Board of Education. Mothers of children attend school one day each week in order to learn techniques for carrying out the recommendations of the specialists in the school. Although this program is unquestionably the best in the State so far, it is obviously inadequate to meet the needs of the known cases even in the immediate area. Inquiries were also made of

94 other institutions, such as convalescent homes, boarding homes and sanitariums. Of these, 10 reported that they accepted mentally normal spastic children for care. Only four of these 10 institutions have medical supervision and facilities for physical therapy; the remaining six provide custodial care only. Three of the four institutions which accept the children are privately operated; the fees range from $75 to $150 a month.

Cerebral palsied persons who are mentally retarded are accepted at Sonoma State Home where they are about 350 at present, and at Pacific Colony, where there are 162. There are 27 private institutions accepting mentally retarded children, which are licensed by the State Department of Institutions. In only two of these are cerebral palsied children specifically listed as being eligible for admission.

RECOMMENDED PROGRAM

FOR THE CARE AND EDUCATION OF CEREBRAL PALSIED CHILDREN IN CALIFORNIA

In order to provide adequate care and education for children with cerebral palsy and to give their families the help which is essential for developing the capacities of these handicapped children, expansion of existing public health and educational services is needed. The State Departments of Public Health, Education, Institutions, and the University of California Hospital and School of Education all have some facilities now for serving these children, but there is need to coordinate these and to fill in certain major gaps. By building on these existing facilities, it will be possible to provide care to a far greater extent and at a lower cost than might be expected for dealing with so complex a problem. The accompanying diagram shows the functional units of the departments which can provide treatment and education for cerebral palsied children and the proposed interrelationships of those departments. The structure and functions of the individual units of service in the overall program are as follows:

HOSPITAL-SCHOOLS. The nature of cerebral palsy is such that medical care, physical training and academic education must be carried on simultaneously so that the child may develop in all respects at a corresponding rate. Therefore, it is recommended that two hospital-schools, one in San Francisco serving northern California, the other in Los Angeles serving southern California, be established. Each hospital-school should be composed of two divisions working as a closely knit unit. One of these divisions would be primarily medical and the other educational.

The diagnostic and treatment division in San Francisco could well be developed as an integral part of the University of California Hospital. This hospital already has departments of pediatrics, orthopedic surgery, psychology, psychiatry, neurology and physical therapy, with trained personnel. The University School of Education is concerned with the training of teachers for exceptional children and is staffed with educators who can administer the education division of the proposed hospital-schools. With some additional personnel specially trained in the treatment and education of cerebral palsied children and with some additional space and equipment, excellent diagnostic treatment and educational services can be developed.

In establishing the hospital-school to serve southern California, it is recommended that the State enter into a contract with an existing hospital having facilities for crippled children for the establishment of the diagnostic and treatment unit and with the School of Education of the University of California at Los Angeles administering the special school in conjunction with the medical unit.

Diagnostic and Treatment Division. The child's diagnosis and recommended treatment must be based not only on physical examination requiring time and highly specialized skill, but also on expert psychometric and personality studies to determine the type of treatment which is most likely to produce the desired result, namely, that of teaching the child to become as nearly independent physically as his individual capacities and current knowledge and skills make possible. Treatment should include medically supervised training in systematic relaxation and muscle re-education, physiotherapy, psychotherapy, and occupational therapy. In some instances, surgery will also assist a child to walk or use his arms more effectively.

In addition to the diagnosis and treatment of individual patients in this branch of the hospital-school, opportunity would be afforded for research into the causes, prevention, and most effective treatment of cerebral palsy. An added value would be that of training much needed professional personnel to aid cerebral palsied children and their families in their own homes to which most of the children will be returned after their stay at the hospital-school. Such personnel would be afforded excellent opportunities for education and experience in the diagnosis, treatment and instruction of the victims of cerebral palsy.

Residence and Day Schools. At the same time that the cerebral palsied child is being given treatment for his physical handicap, a special education program adapted to the evidenced capacity of each individual should be provided. A special school should be established adjacent to and closely coordinated with the diagnostic branch of the hospital-school. This school should combine special motor and speech education with a regular education program geared in tempo and specific experiences to the characteristic tension and excitability of the cerebral palsied child. Such a school should serve children who will be returning to their homes and to the special education program of their local school district during the period of diagnosis at the diagnostic center; it should also serve as a resident school for children from less populous school districts where no program of special education can be maintained; and finally, it should serve as a residence school for children whose families are unable to provide the necessary physical care.

Such a specialized school would serve three other important functions. It would become a center for the education of parents in the home care of the cerebral palsied child. It would be a demonstration and practice center for the education of teachers. It would make possible much needed research in the education of such children.

FIELD CLINICS. Already functioning throughout California under the auspices of the Crippled Children Services of the State and local health departments are clinics which are responsible for case-finding, preliminary diagnosis, and follow-up of cerebral palsy cases as well as other crippled children. Cerebral palsy cases found by the workers attached to these clinics would be referred to the medical division of the hospital-school for diagnosis and treatment. At present, the State Crippled Children Services has little to offer cerebral palsied children because of the lack of the combined medical and educational facilities which are so urgently needed. In addition to their case-finding functions which the field clinics are already organized to carry out, follow-up services on children whose treatment has been begun in the hospital schools, can be rendered. Physical therapists will be needed to continue treatment of those children returning to their home communities. Some additional medical social workers and public health nurses will be required to assist in the continuing development and adjustment of the child in relation to the local public schools and to his own home.

CUSTODIAL CARE FOR THE SEVERELY HANDICAPPED. Although most cerebral palsied children can be helped sufficiently that they can return to live with their own families in varying degrees of independence, some 30 per cent of the cases are usually found to require custodial care because their capacities are so limited. These severely handicapped persons are more efficiently cared for in institutions separated from mentally defective persons who suffer no physical handicap. This responsibility lies with the State Department of Institutions, which has included in its postwar planning a separate institution for physically handicapped mentally retarded children.

SPECIAL CLASSES IN PUBLIC SCHOOLS. As the work of the hospital-schools progresses, larger numbers of children will be enabled to live successfully in their own homes and to attend the public schools if special classes are provided for them, where education and physical therapy can be provided concurrently. Some such classes have been established, but the work needs to be greatly extended and correlated. A supervisor of special education should be added to the staff of the State Department of Education to give local school districts assistance in the development of special classes and to coordinate this program with the work of the hospital-schools. In addition to appropriate non-competitive education in the usual school subjects, arrangements for physical therapy carried out in the schools under the direction of the State or local Departments of Public Health will be needed.

VOCATIONAL REHABILITATION. In the group of at least 70 per cent of the children with cerebral palsy who can learn to care for themselves, some will be able to overcome their handicap to the extent of being wholly or partially self-supporting. The Bureau of Vocational Rehabilitation in the Department of Education is already organized to work with the handicapped, but some expansion of their services to work with the highly specialized problems of the cerebral palsied may be necessary to provide opportunities for the fullest development of those older children who are helped toward independence by the other units of the cerebral palsy program.

How the Program Would Work

Any child in the State suffering from cerebral palsy may attend the nearest field clinic for preliminary diagnosis. If the parents wish to take advantage of the facilities offered, they will be referred to the hospital-school. In this center, after careful study, each child will be classified as to his present and potential capacities and a plan of treatment and education outlined with the parents. Some of the children can return to their own homes where a simple muscle re-education plan can be carried out by the parents under the supervision of a physical therapist. Those children if of school age, can attend regular public school or special classes as their condition warrants. Other children more severely handicapped will require periods of intensive treatment and education in the hospital-school before returning home. Another

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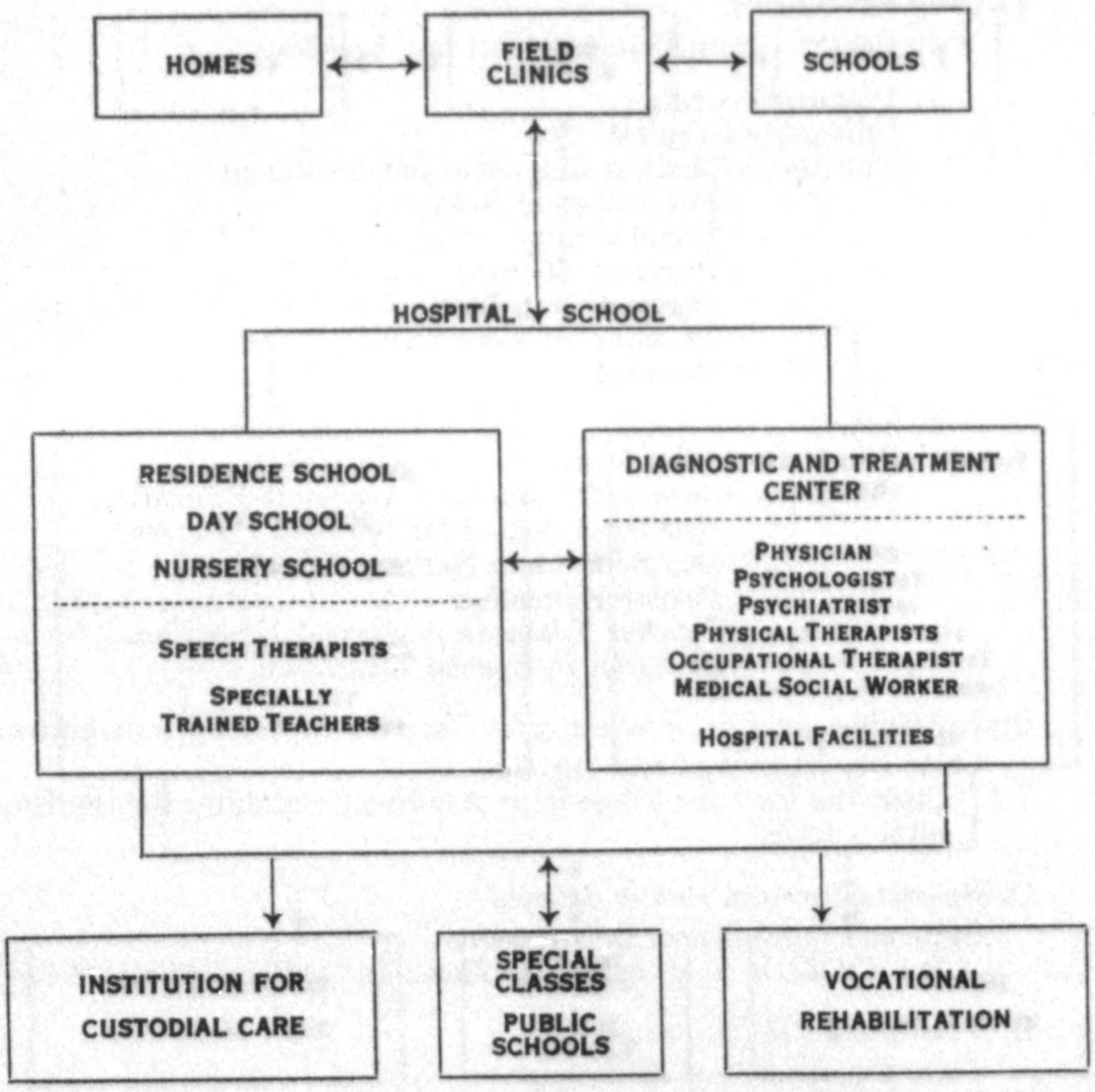
group will be so severely handicapped physically that prolonged periods in the hospital-school will be required. Some children will be recommended to remain in the residence school because of social problems in the home or because the family lives in an area where it will not be possible to develop local physical therapy and special school facilities. The children who require custodial care will be referred to the State institution for physically handicapped mentally retarded, if the parents so wish.

The progress of all the children accepted for care will be followed by the staff of the hospital-school and those who will benefit by vocational rehabilitation will be referred to that agency.

Financial Participation by the Parents

The parents or guardians of children accepted for care under the program should be expected to pay for the costs of treatment and care to the full extend of their ability to do so. Procedures would be established along the lines now existing in other phases of the Crippled Children Services for careful consideration of each family's financial circumstances and resources in order that plans for such financial participation might be worked out. This, of course, would involve all costs exclusive of education and attendance at diagnostic clinics which are now available without cost to the family and would continue to be so.

RECOMMENDED STATE-WIDE PROGRAM FOR THE CARE AND EDUCATION OF CHILDREN WITH CEREBRAL PALSY



RECOMMENDED STATE-WIDE PROGRAM FOR THE CARE AND EDUCATION OF CHILDREN WITH CEREBRAL PALSY

Administration and Functions of the Various Units

A. *Field Clinics*
  State and Local Departments of Public Health (Crippled Children Services)
  Case-finding and follow-up, Field physical therapy, orthopedic nursing and medical social services.

B. *Hospital-Schools*
  Two Centers—San Francisco and Los Angeles

  1. Diagnostic Center
     University Hospital
     Functions—Medical diagnosis and treatment
       Psychometric Study
       Social Study
       Physical Therapy
       Occupational Therapy
       Training of Personnel
       Research

  2. School
     University of California
     Functions—Speech Therapy and Academic Education
       Residence School for Selected Children
       Day School and Nursery School
       Parent Education
       Teacher Training in Special Education
       Research in Special Education

C. *Institution for Custodial Care for Severely Handicapped Children*
  State Department of Institutions
    Custodial Care for Those Who Are Not Candidates for the Hospital-Schools

D. *Special Classes in Public Schools*
  State and Local School Departments
    For Children Able to Live at Home and Attend Public School

E. *Vocational Rehabilitation*
  State Department of Education
  Bureau of Vocational Rehabilitation for Older Children

ESTIMATED COSTS OF PROGRAM

Hospital-Schools
  Medical Units (University of California Hospital)
    Equipment------------------------------------$5,000 per school
    Personnel and Operating Expenses-----$36,000 per year per school

  School-Units (University of California—School of Education)
    Personnel and Operating Expenses-----$70,000 per year per school
    Construction and Equipment of School Building--$200,000 per unit

  Field Services (State Department of Public Health)
    Personnel and Expenses----------------------$40,000 per annum

  Coordination of Education of Physically Handicapped in Public
      Schools (State Department of Education)
    Personnel and Expenses----------------------$20,000 per annum

SUMMARY OF A STUDY OF THE EDUCATION OF CHILDREN WITH CEREBRAL PALSY IN THE STATE OF CALIFORNIA[4]

Following the passage of Concurrent Resolution No. 30 by the California State Legislature on April 23, 1943, the Department of Education undertook a study designed to secure basic data concerning the education of crippled and spastic children within the State.

Education of Physically Handicapped Children

Under existing laws,[5] the Superintendent of Public Instruction is required to apportion to each elementary or high school district additional amounts equal to the excess cost of educating physically handicapped children during the preceding school year as reported by the county superintendent of schools. The apportionment may not exceed two hundred dollars ($200) for each unit of average daily attendance of physically handicapped children in the district during the school year.

Under the provisions of Chapter 9, Education of Physically Handicapped Minors,[6] school districts may make such special provisions as in their judgment may be necessary for the education of physically handicapped minors. Such physically handicapped minors may be instructed in special schools or special classes, in hospitals, sanatoriums, or preventoriums, in the home through the employment of home teachers, by cooperative arrangement with the Bureau of Vocational Rehabilitation of the State Department of Education, or by any other means approved by the State Department of Education.

In the elementary schools of California, service to physically handicapped children has increased from 2,910 children in 1934-35 to 4,493 in 1943-44, the last year for which figures were available in the State Department of Education. In the following table (Table I) the excess cost apportionments and average daily attendance of physically handicapped pupils in elementary schools by types of classes are shown for the 10-year period from 1934-35 to 1943-44.

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[4] A comprehensive study of the education of children with cerebral palsy in California is presented in a 165-page typewritten manuscript prepared by Lois R. Schulz and available in the office of the Division of Elementary Education, California State Department of Education.

[5] *Education Code of California, 1943*, Sections 6954, 6976, 7106, 7138.

[6] *Ibid*, Sections 9601-9644.

TABLE I

Excess Cost Apportionments and Average Daily Attendance of Physically Handicapped Pupils by Types of Classes and by Years in Elementary Schools

		Average Daily Attendance of Previous Year In Elementary School			
Year	*Excess cost apportionment*	*Individual instruction*	*Remedial classes*	*Special day classes*	*Total*
1943-44	$756,279.64	848	931	2,714	4,493
1942-43	806,465.44	1,051	817	3,068	4,930
1941-42	810,859.04	973	818	3,144	4,945
1940-41	773,030.72	890	682	3,306	4,878
1939-40	667,241.36	839	533	2,860	4,232
1938-39	627,094.42	717	595	2,779	3,991
1937-38	598,214.78	609	---	3,220	3,829
1936-37	556,774.34	618	---	3,073	3,804
1935-36	594,769.24	558	---	2,870	3,428
1934-35	424,750.22	380	---	2,530	2,910

In the secondary schools of California, service to physically handicapped children has increased from 343 children in 1934-35 to 1,704 in 1943-44. In the following table (Table II) the excess cost apportionments and average daily attendance of physically handicapped pupils by types of classes in secondary schools are shown for the 10-year period from 1934-35 to 1943-44.

TABLE II

Excess Cost Apportionments and Average Daily Attendance of Physically Handicapped Pupils by Types of Classes and by Years in High Schools

		Average Daily Attendance of Previous Year In High School			
Year	*Excess cost apportionment*	*Individual instruction*	*Remedial classes*	*Special day classes*	*Total*
1943-44	$276,786.98	554	137	1,013	1,704
1942-43	302,804.00	655	149	1,054	1,858
1941-42	283,349.64	695	134	1,093	1,922
1940-41	232,615.46	549	148	905	1,602
1939-40	186,943.52	325	140	693	1,058
1938-39	177,948.98	284	91	603	978
1937-38	91,210.48	163	---	369	532
1936-37	83,095.82	123	---	382	505
1935-36	67,123.70	107	---	327	434
1934-35	60,949.44	81	---	262	343

It is apparent from the foregoing figures that steady growth is being made in California in meeting the educational needs of physically handicapped children in the elementary and high school either through special day classes, remedial classes, or in cases of extreme disability through individual instruction given by teachers in the home of the physically handicapped pupil.

Survey of Children With Cerebral Palsy (Spastics)

Inasmuch as Concurrent Resolution No. 30 made special reference to the problem of cerebral palsied children, the Department of Education undertook a state-wide survey. A preliminary questionnaire was sent to city, county, and district superintendents, to high school principals, and to directors of private schools. This preliminary inquiry served as a device for locating the children with severe cerebral palsy. Detailed questionnaires were then sent to all respondents who stated that spastic children were in the school or resided in the community. One questionnaire was designed to obtain information regarding the educational procedures followed by the school; the other, to procure information about each child. It was anticipated that this procedure would yield a state-wide picture of the educational facilities available for cerebral palsied children which might be evaluated as to adequacy in meeting the needs of such children between the ages of three [7] and sixteen years.

Personal visits were made to 15 schools, and information gained from observation and conferences with school personnel was incorporated into the data obtained from the questionnaires.

Nature of Cerebral Palsy

The treatment and prognosis of cerebral palsy are complicated by the varied manifestations of the disorder. The severity of involvement ranges from a slight to an incapacitating extent; it may involve one limb, one side of the body, or all four limbs.

The physical appearance of the spastic child and his aimless gestures contribute to the impression of mental as well as physical incompetence. Involuntary motion which takes place in the muscles of the face as well as the muscles of the arms and legs produces contortions and grimaces which on first sight appear to mark such children as definitely feeble-minded. The characteristic of cerebral palsy is for the muscles to respond maximally to any stimulus applied to them. The basis of this response is motor, however, and is not due to emotional imbalance or feeble-mindedness.

The basic movements—reciprocal kicking to walking, reaching or grasping to self help, vocalized breathing to speech—are almost inherent in the growing process of the normal infant but have to be taught to the child with cerebral palsy. Abnormalities of the neuromotor system may interfere with these basic learnings so that the spastic child can not learn them or can only acquire very limited skill with them. The more complicated movements are dependent upon these primary ones. If, however, the basic movements have been learned by the spastic child, it may be possible to teach him the more complicated ones. The primary goal toward which the training of the spastic child should be directed are the normal activities of walking, eating, dressing, and speaking. To the degree that these can be acquired, the cerebral palsied child is educable.

The Incidence of Cerebral Palsy in School Children

Statistics show the incidence of cerebral palsy to be second in the diagnostic classification of all crippling conditions. For several reasons the public has not been cognizant of this large incidence. The inadequate medical resources to treat cerebral palsy patients have discouraged parents from bringing their children to a clinic or hospital. The physical inadequacy of the individual with cerebral palsy has made him socially unacceptable, and families have therefore endeavored to shield him from

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[7] *Education Code of California, 1943*, Section 9609 provides that minors "suffering the effects of spastic paralysis may be admitted at the age of three years to special schools or classes established for such minors."

the unsympathetic attitude of people who misunderstand both the etiology of the lesion and the mental status of the individual. Educational facilities have been available, for the most part, only to those spastics whose degree of physical involvement is mild. Finally, there has not been compulsory State registration because the disease is not communicable.

The most reliable nationwide statistics indicate that there is an annual increment of 7 cerebral palsied children for each 100,000 of the population. Of these 7, one dies before reaching the age of six, thus leaving six for every age group. In this way it is assumed that there are 96 cerebral palsied children under the age of 16 for every 100,000 of the general population.

Applying this ratio to California, the number of children with cerebral palsy in the State would be about 7,680 on the basis of the present 8 million population. Authorities estimate a ratio of 54 educable cerebral palsied children under sixteen years of age for each 100,000 of the general population, which for California would mean a school responsibility for 4,320 children with cerebral palsy.

The reports from the questionnaire of this survey do not locate this number of children. There are several reasons to account for this discrepancy: (1) inflated state population, (2) census limited to school records, (3) compulsory school attendance beginning at age eight, (4) children with mild degree of involvement adjusted to the school and not reported, (5) severe cases not publicized, (6) schools without medical service, (7) school personnel not qualified to diagnose. The ratio previously stated of 96 for each 100,000 of the population included ages 1 to 16; while those reported by California school authorities would include for the most part only those within the compulsory school age of 8 to 16.

The survey in California yielded reports for 798 individual children of school age with cerebral palsy from the following groups:

Public schools		556
Children in school	457	
Children not in school	99	
Private schools		54
State schools		2
State institutions		186
Total		798

The detailed data from 798 records form the basis for the further study of the educational facilities for children with cerebral palsy in California. A census of 798 spastic children under 16 years of age can not be considered the total number of spastic children in the State, but needs, rather, to be recognized with the limitations attendant a first school census obtained from records not primarily compiled for that purpose. This was a significant factor in reducing the number reported by the preliminary inquiry. The number, 798, is further reduced, however, by the 186 feeble-minded patients who are cared for by the Department of Institutions. The minimum of the size of the school problem, with regard to number of spastic children may be considered, therefore, as one providing for 500 pupils. The experience of the crippled children's services in regard to other handicapped groups has been that when more adequate programs are provided, these "hidden children" quickly appear. It can safely be predicted that under an active statewide medical-educational program the known number of spastic children in California will increase rapidly.

Problems Involved in the Education of the Cerebral Palsied Child

The survey revealed the areas of physical malfunctioning which made each child a deviate in the school situation. For some children the disability was noted in one or more areas, such as speech, locomotion, and self-help, whereas for others it was shown only by disturbance in locomotion. The three major areas of physical deviation were speech, self-help, and locomotion. Impairment in vision was noted in 21 cases; in hearing in 4 cases.

Locomotion. More than 200 children were reported with marked difficulty in locomotion. Numerically, this is first in occurrence in all types of motor disorder. The significance of independent locomotion to school attendance is obvious. In general, the children who can not walk are enrolled in special schools, taught by a home teacher, or are lacking in school opportunity. Some typical examples of this locomotive difficulty may be noted from the report.

> An 8-year-old boy in a special school; completely dependent.
> 9-year-old X7 is just learning to walk with cane after using wheel chair.
> A 9-year-old girl who is able to walk in a framework with wheels.

The abnormality of response of the leg muscles is conspicuous by the scissor gait or by toe walking. The teachers report on some of these as follows:

> An 11-year-old has a "shuffling gait."
> A 7-year-old now can "stand on toes when supported."
> Girl, age 4-4, "is unable to take steps as she has a severe scissor gait; can be assisted to walk with ski shoes."

The difficulty of maintaining balance makes falling an ever present danger. Examples of this were reported in various degrees of severity and indicated an influence on the child's participation in school activities:

> An 8-year-old boy falls easily and has difficulty in getting up.
> An 11-year-old boy is "unsure of himself when walking, falls more than the ordinary child does."
> R8, age 10-7, "was unable to take more than two steps without support at 8 years of age. He had a skinned nose which never healed because he was always falling on his face. Can now walk and run some."

Self-help. Second in number of times reported were physical disturbances involving the arms, hands, or both. The following examples from reports in this study are typical:

> Girl, 13 years old, right hand is helpless.
> Ten-year-old girl eats fairly well alone and manages to dress herself partially.

A 14-year-old girl who does walk but only short distances, is unable to use her hands but writes and feeds herself with her feet, has a good mind and reads on a level with children of her age.

Speech. Various parts of the speech mechanism may be involved in cerebral palsy. Reverse breathing is characteristic of many spastic children. As a result only soft sounds can be made. One of the most handicapped children reported in this study was a six-year-old boy who had what may be called "silent speech." Although he is able to direct his tongue muscles to the proper movements, it is only very occasionally and when he is completely relaxed that any sound can be heard.

Speech is further disturbed by muscular difficulties. The posterior portion of the tongue may interfere with swallowing. The difficulty experienced by the spastic child in swallowing his saliva is a common and distressing symptom in this respect. The case is reported by a special school in a city school system of an eight-year-old girl who constitutes a true schoolroom problem. The teacher writes:

> X3 is a schoolroom problem. She is extremely difficult to understand. She drools on people and whatever she is near, paper, furniture, books. She wears a bib all day because of excessive drooling.

Difficult Areas in Learning Situations. The following problems were reported as typical in the teaching of cerebral palsied children:

1. Speech
   - Uses a sign language with various grunts
   - Makes series of different pitched tones
   - Good mind but unable to speak through lack of coordination
   - Nervous and stutters, when checked in his reading will slow down, lower his voice, and read almost without stuttering
   - Unable to speak clearly or rapidly
2. Writing
   - Difficult to write legibly
   - Uses typewriter slowly with many errors
   - Very shaky and finds it difficult to write
3. Motor Control
   - Difficult to handle materials and tools
   - Difficult to hold materials
   - Difficult to see blackboard because of position of head
   - Difficult to move to classes
   - Difficult to move about easily; unable to do laboratory experiments
4. Emotional Control
   - Dismissed from school because of problems of discipline
   - Very emotional; a behavior problem probably due to poor vision
   - Hard to deal with; highly nervous
   - Too nervous to attend regular classes; was assigned a home teacher
   - Has given evidence of high temper in the past but seems to have achieved better control
   - More nervous than he used to be; cries easily

5. Slowness
   Is incapable of movement if hurried
   All movements slow
   Needs to move at a slower pace than that afforded in regular classes
   Slow in oral expression
   A slow writer
6. Reading
   Eye coordination seems poor
   Spasticity has affected eye muscles
   Seems to have no fusion ability
   No readiness for reading
7. Influence of group
   Spasticity increases when child is in group and learning becomes slower
   Restless in a crowd and demands much personal attention
   Reacts with increased nervousness to group stimulation
8. Arithmetic
   No apparent conception of the meaning of number
   Slow in all work involving number
9. Art
   No ability to draw
   Can use only large motions
10. Spatial relations
    Unable to judge distances accurately
    Unable to grasp and hold objects

It is evident from the many reports from teachers that the spastic child experiences great difficulty in learning and requires a great amount of individual attention from specially trained teachers to enable him to make his maximal progress.

Evaluation of Mental Status. A different type of problem, but one upon which academic success is dependent, is the determination of the educable potentialities of these children. The professional literature is convincing in regard to the complications which confront the individual who attempts to measure the mental status of the child with cerebral palsy. Because the present instruments of measurement emphasize verbal or motor responses, the evaluation of the intelligence of the cerebral palsied child is one of the major problems in planning education for him. In testing the cerebral palsied child, tests should be used which have the following characteristics: (1) few verbal responses required, (2) fine muscular coordination not required, (3) the time factor should not be important, (4) the degree of difficulty should challenge the subject, (5) some indication of the subject's ability to apprehend a variety of relationships should be indicated, (6) testing periods should be flexible in regard to time and number of tests, (7) the situations used in the tests should be within possible experiential limits of spastic children.

Information regarding the educability of the children in the schools reporting in this survey was given in various ways. Intelligence quotients were given for 113 children in the public schools. These were obtained from different tests; for 41 children, from either form of the

Binet; for 89 children, from a combination of the Binet and some individual performance test; and for 33 children, from either the Otis, Kuhlman, California Mental Maturity, or some other form of group test. The frequency and range of scores of these 113 children is shown in Table III, Evaluation of Educability as Based on Tests.

TABLE III

Evaluation of Educability as Based on Tests

Intelligence quotient	*Test Used* *Binet*	*Binet and performance test*	*Group test of intelligence*	*Total*
30- 40	0	2	0	2
40- 50	1	5	2	8
50- 60	2	6	3	11
60- 70	6	8	5	19
70- 80	7	3	6	16
80- 90	8	7	4	19
90-100	8	5	8	21
100-110	2	2	4	8
110-120	5	1	2	8
120-130	1	0	0	1
130-140	0	0	0	0
140-150	0	0	0	0
150-160	1	0	0	1
Total	41	39	33	113

Further light on the educability of spastic children was supplied by the teachers' estimates in cases where the results of tests were unavailable. The teachers reported that 13 children had reached the limit of educability; 33 were unable to achieve a passing grade; 16 were classified as "passing for ability"; 55 were classified as poor in academic achievement; 30 were average; 103 were fair; 79 were good; 21 were "good but retarded," and 30 were excellent. Reports concerning the educability of spastic children were received on 62 cases as follows: 23 were considered educable, 19 were noneducable, and 20 were questionable.

From the data the inference seems justifiable that the majority of children known to the school personnel have educable potentialities. Considering the 74 children who are reported to have intelligence quotients above 70, the 290 whose performance level of school work is above passing, and the 16 who were rated educable, there are 350 or more children of the 490 reported by the public schools who may be considered entitled to school opportunity. In any event, the results of these inquiries indicate the importance of some definite plans of psychometric examination of cerebral palsied children by expert psychologists in order that the best possible educational planning may be done for each individual child.

In summary there are several points which stand out as important. Low mental capacity is not necessarily a concomitant of a cerebral lesion. Because the mental status cannot be measured with present methods, it cannot be assumed that mental deficiency exists. Evaluation of intellectual capacity should not be confused with judgment of physical inadequacy. In many cases the child's ability to learn is a better index of his mental status than any evidence of speech or motor skill. Because of his deviation, the cerebral palsied child's progress should be measured in terms of his own rate rather than compared with norms on nonspastic groups.

Programs of Other States for the Cerebral Palsied Child

The present concept of social welfare for the physically handicapped child extends beyond medical care to a comprehensive program providing for educational, vocational, and social adjustment of the child. The problem of the education of the child with cerebral palsy is a complicated one in which the resources for care have not kept pace with the research findings relative to his needs. The crux of the problem has been the difficulty in integrating a program of muscle re-education with the standardized school routine. For no other group of handicapped children is the problem of integration of care more significant than for cerebral palsied children.

Reports from the few established cerebral palsy centers in the United States, all in the eastern states, stress this integration in the program. Four outstanding centers exist in the country: the Children's Country Home, Westfield, New Jersey; the Children's Rehabilitation Center, Cockeysville, Maryland; the James Whitcomb Riley Hospital, Indianapolis, Indiana; and Dr. Earl R. Carlson's School of Corrective Motor Education, Long Island, New York. In these centers the focal point has been medical research. The results indicate the importance of adjusting the educational experiences to the children's abilities and disabilities.

Outstanding among the state projects is Maryland's method of referral of cerebral palsy patients to a special diagnostic clinic with opportunity for treatment and care at the Children's Rehabilitation Institute which admits only children with this type of handicap. A child is accepted for a probation period of 3 months, and if he continues to show progress, he is retained as a pupil. The criterion of progress is the ability to learn, to improve mentally and physically. The expense of such an institution is high because there is a staff-child ratio of one to one.

The aims of the James Whitcomb Riley Hospital have been set forth as follows:

1. To correct deformities
2. To re-educate muscular control
3. To stimulate and re-educate undamaged cortical cells
4. To improve rhythm of movements
5. To develop better neuro-muscular co-ordination and balance
6. To improve the tone of weaker muscles
7. To liberate the personality of the child
8. To develop the power of co-ordinate and articulate speech
9. To determine and guide educable possibilities
10. To stimulate mental as well as physical development

This program does in reality attempt to treat the whole child as well as his disease. An important feature of this plan is to continue in the home, the treatment begun in the hospital.

Twenty-seven states now have limited programs under public and private operation for the education and treatment of children with cerebral palsy. These programs are suggestive for California's planning for the education of the cerebral palsied child. They demonstrate the need for a distinct legislative and educational category for the cerebral palsied; they indicate the value of an integrated program that correlates physical training to develop motor skill with academic learnings; they constitute a challenge to education to function positively in the formulation of methods and techniques appropriate to the developmental deviations reported for these children.

Recommendations for Educational Program

It is necessary in planning an educational program for children with cerebral palsy to consider the physical and the mental deviations consequent to the cerebral lesion. The educational prognosis is in many cases confused by the interrelationship of the motor and the mental defect. Wide variations of these conditions as regards degree or type of manifestation may be considered as symptomatic of cerebral palsy.

Educational experiences which can be used by the spastic child will show wide variation. This necessitates defining educational expectations for each child. The educational facilities previously discussed were in relation to the spastic child who was in school. The educability of those children was, therefore, in relation to ability for academic learning. Educability of the spastic child may, however, be considered in relation to motor learning—that degree of mental ability which will enable the child to learn the basic physical skills. An emphasis is placed on the spastic child's acquisition of physical skills as a prerequisite for making academic learning a functional asset to him. Some academic success, even though a limited amount would be considered a criterion for the child's continuing in any long-time educational program. There are spastic children for whom the final goal may be limited to those basic skills of self-help, but it is contended that there is a social obligation to assist the child to the level of accomplishment that is possible for him. This variability in final goal as well as in symptoms has complicated the formulation of an educational program because no single type of instructional program may be considered appropriate for all children with cerebral palsy.

The present practice of including the children with cerebral palsy in the school program of the crippled child has served effectively for some spastic children. There needs to be a distinction, however, in the thinking and the planning for spastic children because there are many for whom the regime of a school for children with all types of handicap is too demanding. The program, planned for the orthopedic cripple who shows a zero response to stimuli, will not be appropriate to the spastic child who gives a maximal response to stimuli. Or in another situation, the crippled child will be passively helpless whereas the spastic child's helplessness may be superimposed with confused, tense, or involuntary movements.

Fundamental to a program in which all spastic children may share is a separate legislative and educational category such as at present exists for the deaf and the blind. A beginning has been made in the permissive legislation admitting children with cerebral palsy at the age of three years to such special schools or classes as may be available to him.[8]

The evaluation of the educational facilities in California for children with cerebral palsy indicated that the modifications now made in the school program facilitated school attendance for a number of spastic children. There were other spastic children, however, who were con-

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[8] Education Code of California, 1943, Section 9600.

sidered to have academic ability but whose degree of physical disorder prohibited school opportunity under present conditions. In relation, therefore, to the total group of spastic children, three services appear essential in a plan designed to give all children with cerebral palsy educational opportunity commensurate with their physical and mental ability: (1) formulation of a state-wide cerebral palsy program with educational services having an integral function in the total plan; (2) continuation of the special education program in public schools for those spastic children for whom it is suitable or for whom adjustment can be made through the regular channels; and (3) establishment of additional educational facilities necessary for a correlated program for children with cerebral palsy.

State Program for Children With Cerebral Palsy

The major emphasis in any State program must be on the coordination of medical, surgical, neurological, educational, and social services. It is apparent from a review of programs reported by other States that an experimental approach is consistent with the present stage of the problem in relation to diagnosis, prognosis, or treatment.

The educational program must be an integral part of the total State program for spastic children and may therefore be considered in relation to the field services as well as to the diagnostic centers.

First in the consideration of any State plan are the field services. The function of the field services should be twofold: (1) to recommend treatment and educational placement for those children who can be cared for through the existing facilities of the community; and (2) to locate cases needing referral to a diagnostic center. The field services, now functioning under the Crippled Children's Division, Department of Public Health, are organized to serve all sections of California. Extension of the service, to provide special clinics for children with cerebral palsy would benefit a large number of this handicapped group. Education should have the responsibility of recommending school placement and making arrangements for the child's admission to the appropriate unit. The facilities of the State's program of special education should be used by this group. It is evident that for social and economic reasons, adjustment within the regular school channels when it can be arranged, is the recommended procedure. For the most part this group would be composed of children similar in type of disability to those 431 who were enrolled in the schools reported in this study.

The survey of State services emphasized the importance of family education in the care and treatment of the spastic child. Such an emphasis has the advantage of being an economy measure but the greater advantage is in keeping the child within the family group.

A second unit in the State organization designed to serve the spastic child would be a diagnostic center. For a State the size of California, it would seem feasible to propose two such centers. There may be noted a concentration of the numbers of spastic children in two sections of the State: one around San Francisco and the San Francisco Bay area; and another around Los Angeles and San Diego. The preschool and school age load is seen to be in similar geographical locations. The numbers of spastic children in these areas reflect, to an extent, the development of the facilities for diagnosis, for treatment, and for special education which have served to draw the spastic children to these sections.

It should be anticipated that every child with cerebral palsy would have the privilege of referral to such a center for the services of specialists who would diagnose and recommend treatment. The establishment of the child's status of educability would constitute one of the diagnostic services. Educational placement would be recommended on the basis of the physical and mental status of the child, the social aspect of the home environment, or the location of the home in relation to needed school facilities.

A short term of residence in the center would be necessary so that the child could be studied under different conditions. A six months trial period and final placement of the child on his ability to learn, to improve mentally and physically seems defensible. Three factors would determine treatment: degree of handicap; mental status of patient; and, evidence of the condition as static or showing possible retrogression. From a specific diagnostic analysis, considering these factors, treatment may be planned to meet the extent of the injury.

A diagnostic center would offer opportunity for research. The greatest obstacle in the development of adequate programs for these children is in the lack of information regarding the whole field of cerebral palsy. Present methods of measuring intelligence, because they place an emphasis on motor or verbal ability of the patient, are not appropriate to the child who has no speech or who can not control or direct his movements. Investigation is needed in such areas as adaptation of teaching techniques in the various subject-matter fields, adjustment of physical facilities and equipment, and formulation of methods and requirements for training teachers of spastic children. A very large emphasis of the total program must be placed upon research.

Educational Program

The formulation of an educational program on the basis of an analysis of the individual reports of spastic children suggests certain areas as major points of emphasis. There must be an integration of services so that the children may have the necessary physical training to develop those motor skills without which academic learnings are not functional.

There must be an emphasis on early training as an integral part of the total program. The very young spastic child is totally dependent for care, and although his needs and desires approximate his chronological age, his motor skills are in conflict with them. The admission age to a school program, according to present law, would be three years, but medical and neurological findings are in agreement that diagnosis and treatment should be instituted at as early an age as evidences of the cerebral lesion are observed.

A program of training teachers to work with cerebral palsied children is greatly needed. The skilled teacher is one trained in many techniques. The teacher training program may be considered from three approaches: requirements which should become legal considerations and thus need to be written into the education code; programs to be introduced into teacher training institutions; and, general policy of requirements for teachers of cerebral palsied children.

Family education is needed in the care and treatment of the spastic child in the home. Teachers of spastic children emphasize the importance of a parent education program planned to aid parents in the care of the handicapped child so the entire family may lead a reasonably normal life. It is often difficult for the members of the family to maintain an objective yet understanding attitude toward the cerebral palsied child and his problems. He must receive help but not constant solicitude. He needs to have some things done for him, yet he must learn to do for himself even though the task is more difficult for him than for others. These distinctions are not easy for parents to make, but are essential to the child's learning process.

Essential to the whole program is the recognition of the relation of the cerebral lesion to a mental defect. In many cases of cerebral palsy, motor disorders reflect mental deficiency and no amount of motor training will compensate for the basic lack.

If the educational placement is to be recommended by specialists in the diagnostic centers and in the field services, an increase in types of school facilities and in modification of instructional services would seem to be indicated. It is proposed that children with cerebral palsy be classified in four categories on the basis of physical and mental development and educational programs planned which will be adapted in facilities and in techniques to the characteristics of each group. The following four categories were suggested from a grouping of the cases referred to in this study: *Group I*, children who can be served by the facilities of the special education programs as they now exist with added services for instruction in motor education and by establishment of special spastic units in schools for crippled children; *Group II*, children of preschool age who manifest varying degrees of involvement; *Group III*, children who require custodial care because of mental deficiency; and *Group IV*, children who have a severe physical involvement or multiple handicap but who evidence mental capacity greater than those children committed to institutions for the feeble-minded. Educational opportunity for these children may be considered as education which will result in personal satisfaction, and have little social or economic value.

It is not expected that arbitrary divisions of these groupings will easily be made nor will it be essential. A feature of the total program would be that of flexibility to permit transfer from one unit to another if the child's condition shows change.

Group I. The children classified in this group would be those for whom educability status is established and whose degree of physical involvement varies. These children can profit by school experiences. For those with a moderate physical handicap, the highly developed facilities of the special education program can provide suitable school opportunities and a wide range of adjustment can be made within the organization of the public school. A basic principle of the planning of the school program for spastic children should be one of adaptation. If the spastic child has the regular educational facilities adjusted to his needs, he is placed in an environment where he can have experiences similar to those of other children.

A favorable prognosis might be expected for the majority of the group when provided with a program of physiotherapy treatments combined with special education. Since this is the group for whom the greatest gains would be noted in physical and mental accomplishments, caution must be exercised in regard to the final goal. Research studies have shown that arrest of development and even retrogression may be expected, but the democratic philosophy of education justifies effort toward giving these children educational opportunity commensurate with their evidenced capacity.

For those children with a lesser degree of muscular co-ordination, emphasis is placed on an enlargement of facilities by the establishment of a spastic unit in the schools for crippled children. The techniques of the classroom in which only spastic pupils are enrolled could be better adapted to the motor and speech disability of these children.

One advantage of a special unit for spastics in a crippled children's school is its proximity to other groups of children who are more competent physically, emotionally, and academically. Complete segregation of all spastic children is not desirable and is not recommended. Particularly in relation to speech it may be advantageous for a child to have association with children who do not exhibit speech abnormalities. This loses its value, however, when the pattern observed daily is too remote from the child's ability of attainment. The aim thus would be to provide school experience from which the child could profit so that by a gradual process he may move from the special unit to the classes for all handicapped children or to the regular school when such becomes possible.

Group II. Group II would be composed of those children below 6 years of age with emphasis on the early preschool years. On the theoretical basis of teaching new motor pathways when the growth impetus is high and before motor habits have been learned, and on the practical basis of the results reported by workers in the field, this is the period which training may be expected to be the most effective. From long observation, administration of many tests, and the combined services of specialists from several fields, a diagnosis, treatment, and prognosis may be formulated for each child. The educational program may then be planned for the child, consistent with his physical and mental abilities.

Preschool units such as these might be thought of in the total plan as day schools similar, for example, to Cottage School in Oakland, or the nursery unit in the Sunshine School in San Diego, and as hospital schools providing 24-hour care. The primary distinction would appear to be in the degree of severity of physical involvement. Location of the home to other preschool units or suitability of the home environment might also be important considerations.

The number of these children reported to the study was affected by the source of the data. The report of 109 spastic children below 6 years of age may be considered only suggestive since for certain large areas as San Francisco, the report was limited entirely to children in the elementary grades. This figure includes those for whom reports were received as well as some for whom name and age only was reported so that it is larger than the group included in the tables in other sections of this study.

Group III. Though this study is concerned primarily with the problems of educable children with cerebral palsy, the numbers of non-educable ones can not be ignored. If the national statistics apply to California's present population, there are in the State more than 3,000 individuals under 21 years of age who are not educable in the sense that they evidence ability in academic work. The reports to this study indicated more than 200 such children including those committed to institutions for the feeble-minded.

There is at the present time considerable public concern regarding the commitment of spastic children to institutions for feeble-minded patients. It is difficult to evaluate the mental status of a child who has not had opportunity to acquire those physical skills by which he may evidence intelligence. A very strong emphasis is needed in the total program toward the development of techniques to determine educability. This is a primary challenge to research. For cases difficult to diagnose, a period of residence in the diagnostic center is recommended so that adequate observation and suitable tests will make possible an evaluation of mental capacity which will not be confused with physical inadequacy.

Group III would, therefore, be composed of children whose mental capacity is not equal to the demands of the school. Acquisition of motor skills would not be expected. These children should be cared for in an institution for feeble-minded patients where they may receive general care necessary for the physically handicapped. Special academic education would not be indicated since improvement could not be expected.

Group IV. There are in addition to these three groups of spastic children, a number for whom both academic and motor learnings are questionable. These are the children who evidence severe physical involvement both as regards area and extent, or a multiple handicap. Physical improvement may be expected to a very limited extent. The mental capacity of these individuals is doubtful but the reports of such cases suggest a level above that used as a criterion for commitment to an institution for the feeble-minded. The disposition of this group of children constitutes a serious problem since the cost of their care will be extremely high in proportion to the degree of improvement that may be expected. One such case reported to this study is that of A9:

> A9, aged 14, is partially paralyzed on her right side, has less than 25 per cent vision and has seizures at intervals. She carries the right hand in a typically spastic manner, but limps only slightly. She has a home teacher for 5 years but last year was in a special school for handicapped children. She benefitted greatly from her social contact with other children but because of the seizures, she was removed. She is able to look after herself almost entirely, can do much in assisting around the house, can read and write Braille.

Conclusion

There is no factor resulting from the cerebral lesion which of itself reduces the life span. Therefore, a correlated program of education and training should continue as long as improvement is noticed in skills of self-help and social competence. The establishment of criteria of progress during the educative process should be a goal of projected research.

There is reasonable hope, according to authorities in the field, that at least some of the effects will be overcome through the processes of growth. Early, persistent, and long-continued programs of muscle training supplemented by judicious use of special therapy and educational methods will go far toward helping the child to obtain a happy and useful if not wholly competent place in the world about him.

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OUR MENTAL HOSPITALS . . . A NATIONAL DISGRACE

By ALBERT Q. MAISEL

Reprinted from LIFE, May 6, 1946

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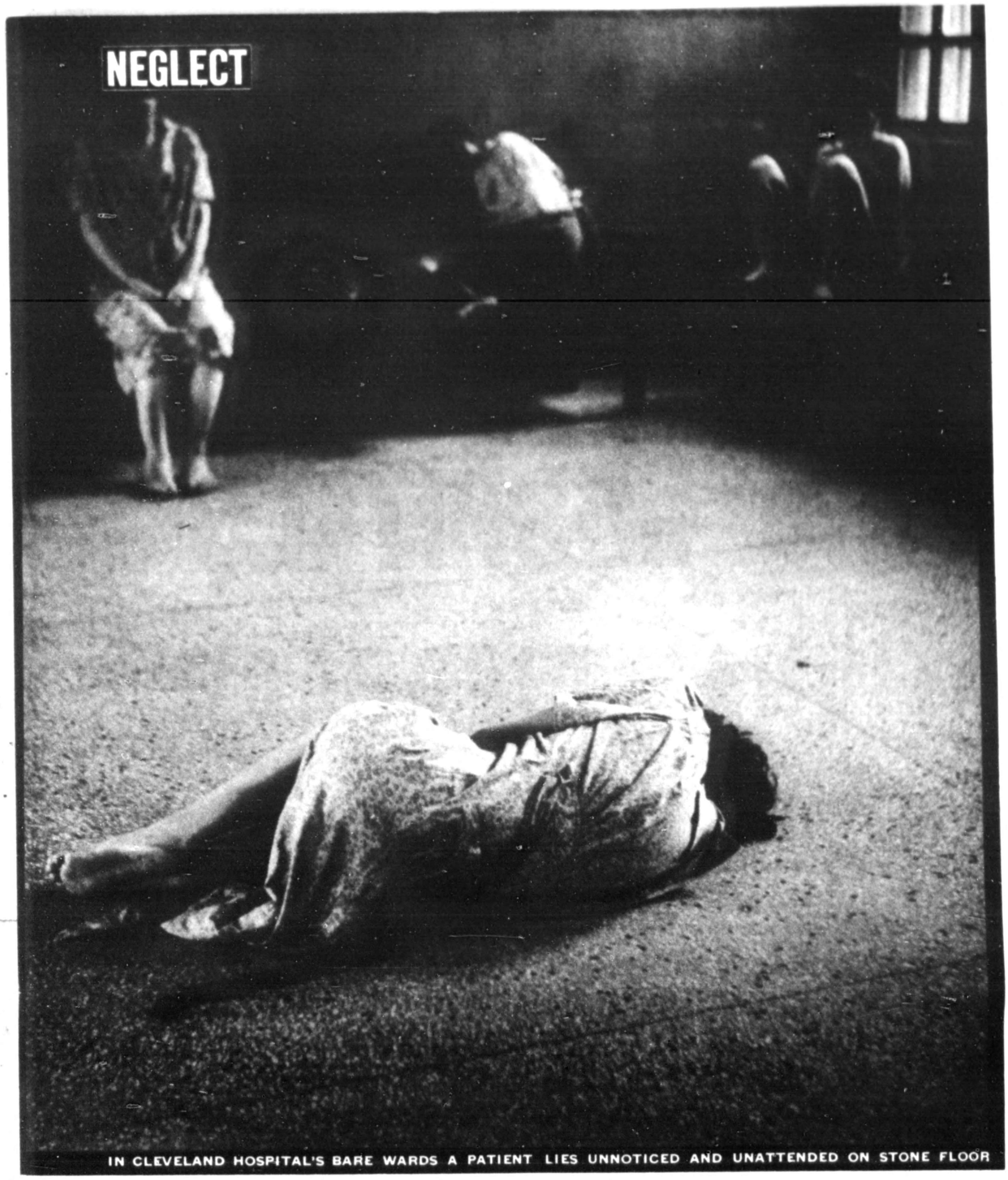

IN CLEVELAND HOSPITAL'S BARE WARDS A PATIENT LIES UNNOTICED AND UNATTENDED ON STONE FLOOR

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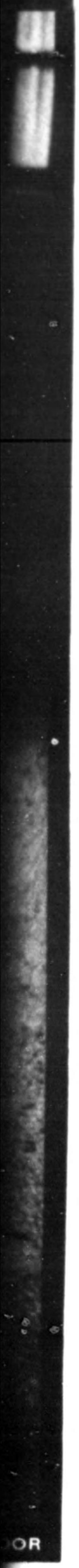

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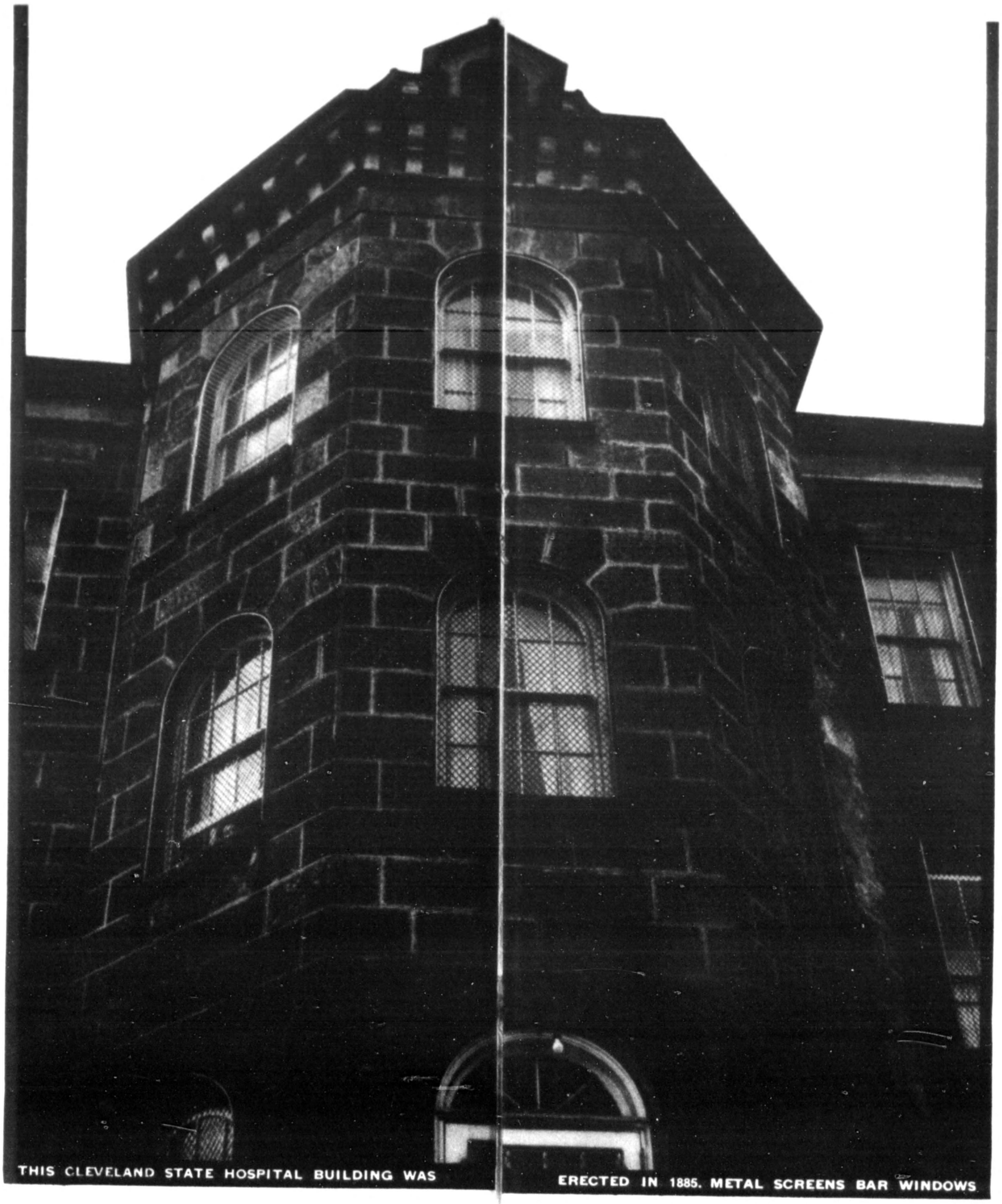

THIS CLEVELAND STATE HOSPITAL BUILDING WAS ERECTED IN 1885. METAL SCREENS BAR WINDOWS

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years on end. One man at Cleveland, Ohio—and he is no isolated exception—worked in this fashion for 19 solid years on a diet the poorest sharecropper would spurn.

Thousands spend their days—often for weeks at a stretch—locked in devices euphemistically called "restraints": thick leather handcuffs, great canvas camisoles, "muffs," "mitts," wristlets, locks and straps and restraining sheets. Hundreds are confined in "lodges"—bare, bedless

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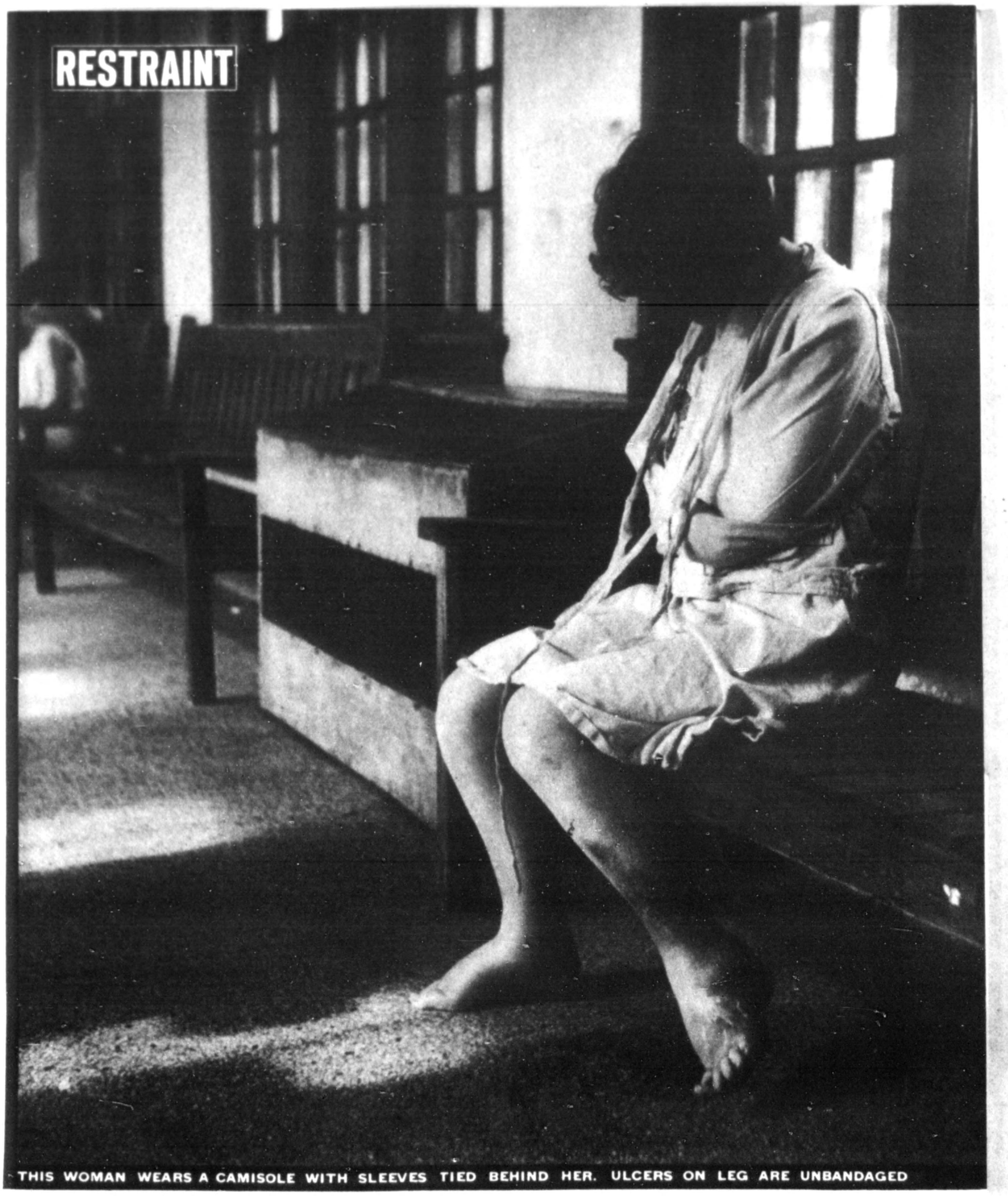

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Nor can any of these horrors be excused on the grounds of "common practice" or as "the best that can be done for the insane." For some states

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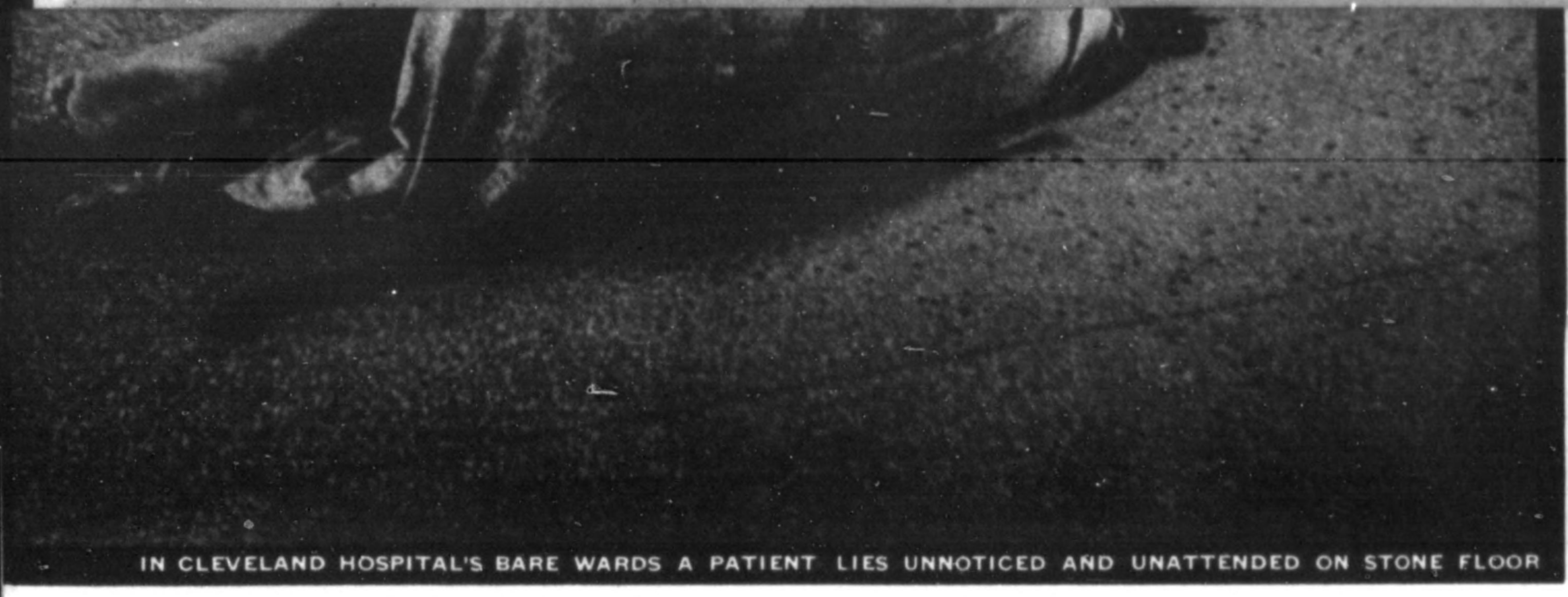

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MOST U.S. MENTAL HOSPITALS ARE A SHAME AND A DISGRACE

by ALBERT Q. MAISEL

The author of this article, through his previous writing and his testimony before a congressional committee, helped instigate important improvements in the Veterans Administration's mental hospitals. The Ohio photographs were taken by Jerry Cooke with the permission of Frazier Reams, Ohio State Commissioner of Public Welfare, and the cooperation of the Ohio Mental Hygiene Association, an affiliate of The National Committee for Mental Hygiene.

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This pitiful memorial might apply quite as well to
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Pennsylvania is not unique. Through public neglect an
pinching, state after state has allowed its institutions fo
of the mentally sick to degenerate into little more
camps on the Belsen pattern.

Court and grand-jury records document scores of de
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short of manslaughter, are similarly documented. And
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Yet beatings and murders are hardly the most signi
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of over 180 state mental institutions.

We feed thousands a starvation diet, often dragged
low-budget standard by the withdrawal of the best food
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dred-year-old firetraps in wards so crowded that the flo
between the rickety cots, while thousands more sleep o
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Hundreds—of my own knowledge and sight—spend
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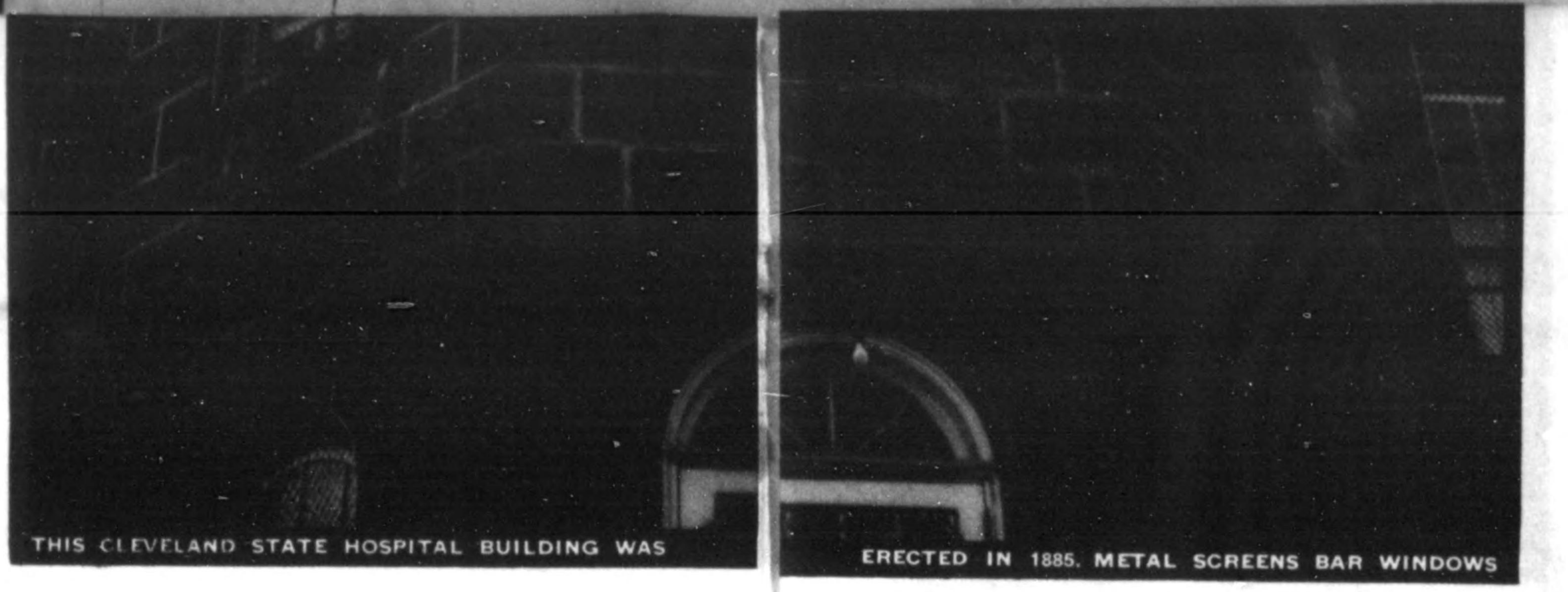

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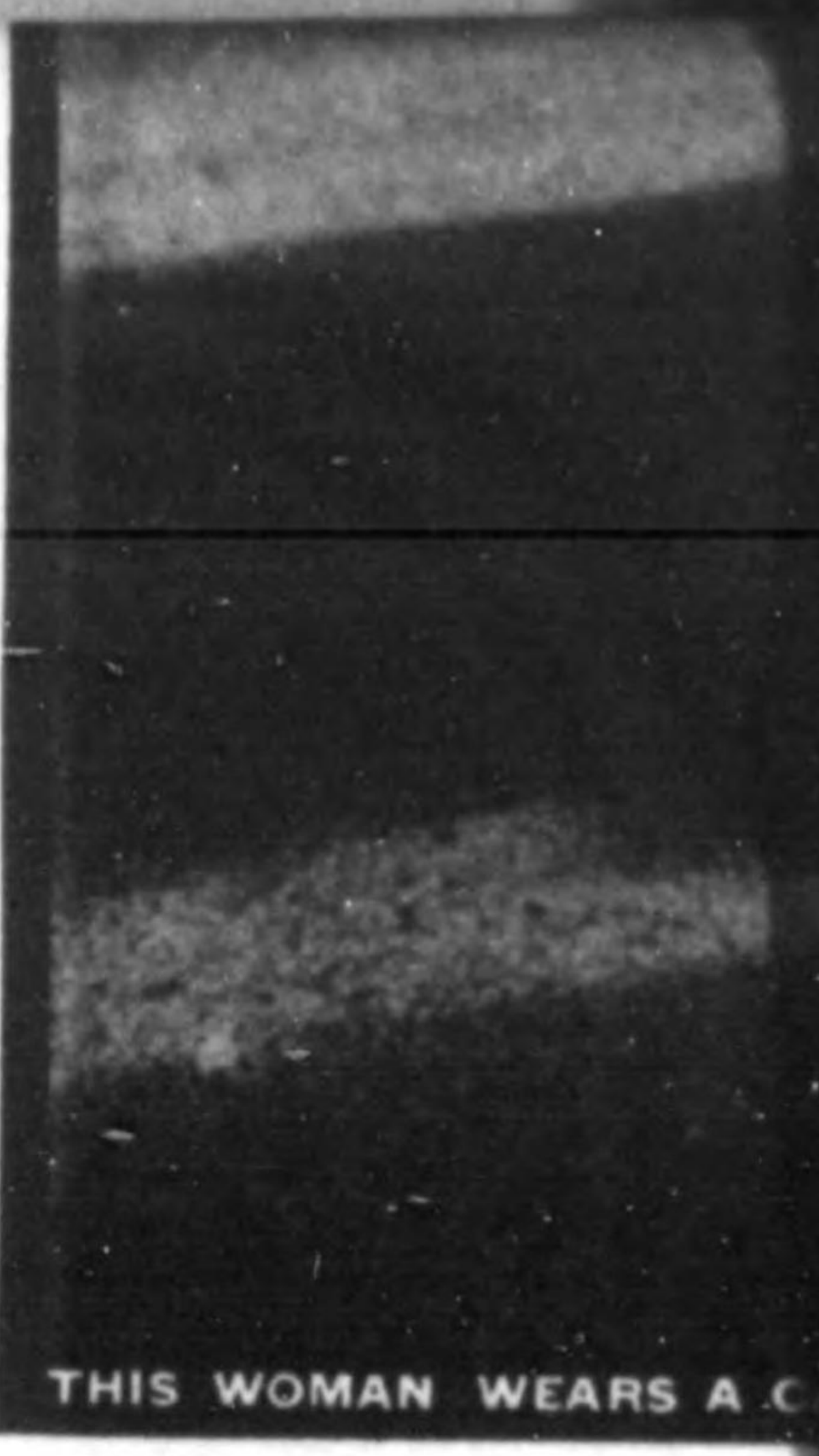

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years on end. One man at Cleveland, Ohio—and he is no isolated exception—worked in this fashion for 19 solid years on a diet the poorest sharecropper would spurn.

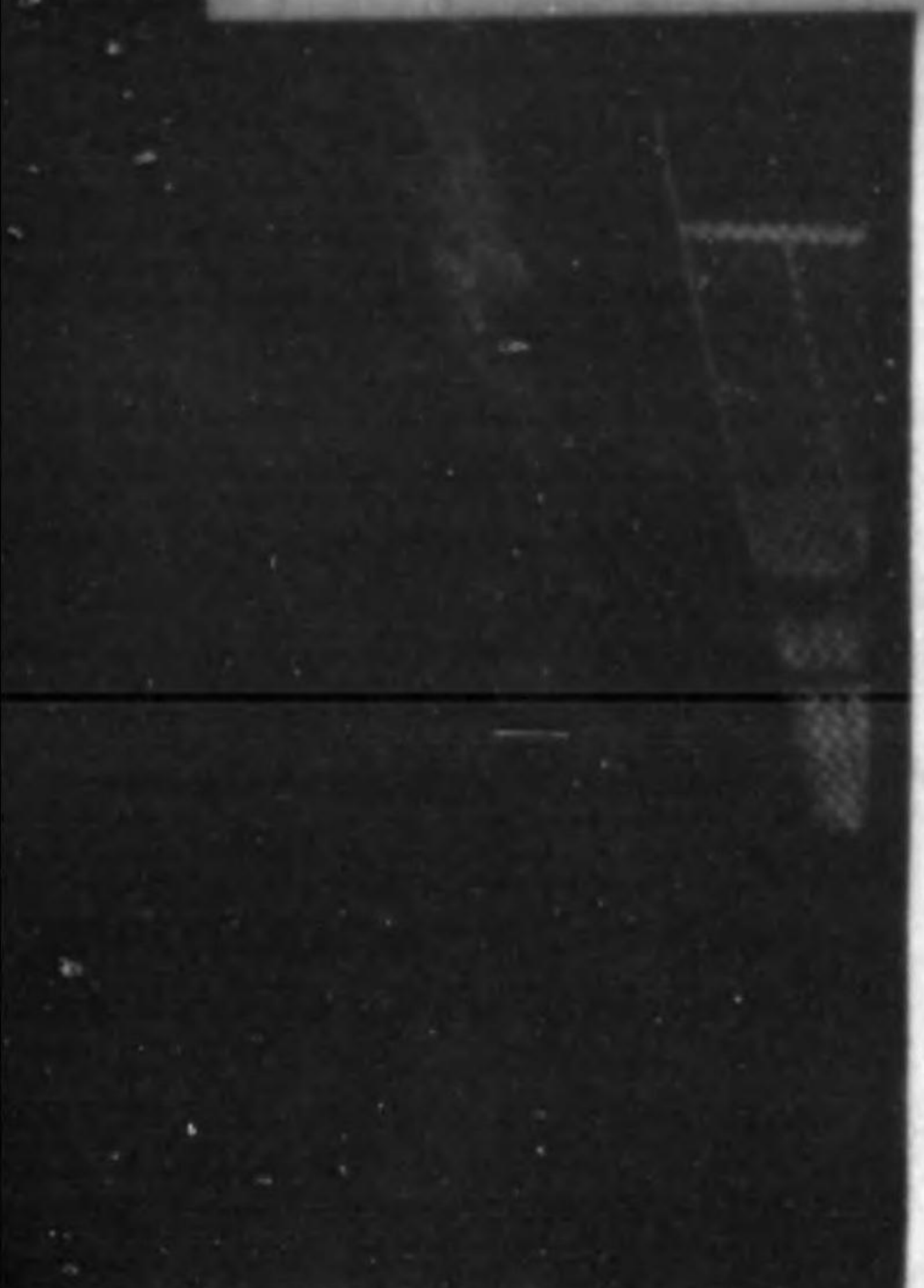
Thousands spend their days—often for weeks at a stretch—locked in devices euphemistically called "restraints": thick leather handcuffs, great canvas camisoles, "muffs," "mitts," wristlets, locks and straps and restraining sheets. Hundreds are confined in "lodges"—bare, bedless rooms reeking with filth and feces—by day lit only through half-inch holes in steel-plated windows, by night merely black tombs in which the cries of the insane echo unheard from the peeling plaster of the walls.

Worst of all, for these wards of society we provide physicians, nurses and attendants in numbers far below even the minimum standards set by state rules. Institutions that would be seriously undermanned even if not overcrowded find themselves swamped with 30%, 50% and even 100% more patients than they were built to hold. These are not wartime conditions but have existed for decades. Restraints, seclusion, and constant drugging of patients become essential in wards where one attendant must herd as many as 400 mentally deranged charges.

Paid wages insufficient to attract able personnel, even by prewar standards, and often working 10- and 12-hour days, these medical staffs have almost ceased (with some significant exceptions) to strive for cures. Many have resigned themselves, instead, to mere custodial care on a level that led one governor to admit that "our cows in the hospital barns get better care than the men and women in the wards."

Thus thousands who might be restored to society linger in man-made hells for a release that comes more quickly only because death comes faster to the abused, the beaten, the drugged, the starved and the neglected. In some mental hospitals, for example, tuberculosis is 13 times as common as in the population at large.

Such conditions cannot be explained away as a result of wartime per-



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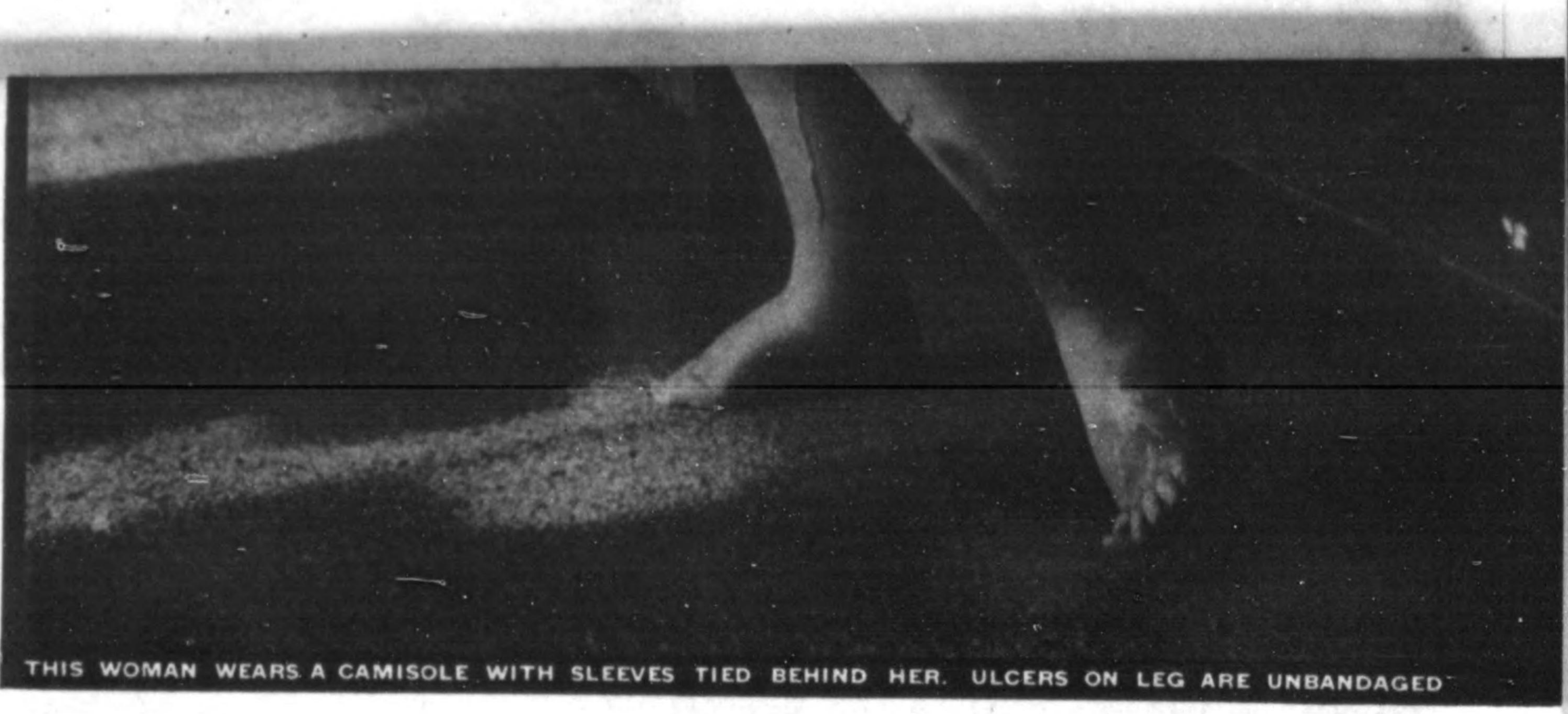

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Nor can any of these horrors be excused on the grounds of "common practice" or as "the best that can be done for the insane." For some states have managed to eliminate overcrowding. Some states discharge, as cured or improved, three and four times as high a proportion of patients as others. A few, notably tiny Delaware, have managed to secure an adequate or nearly adequate number of doctors, nurses and attendants.

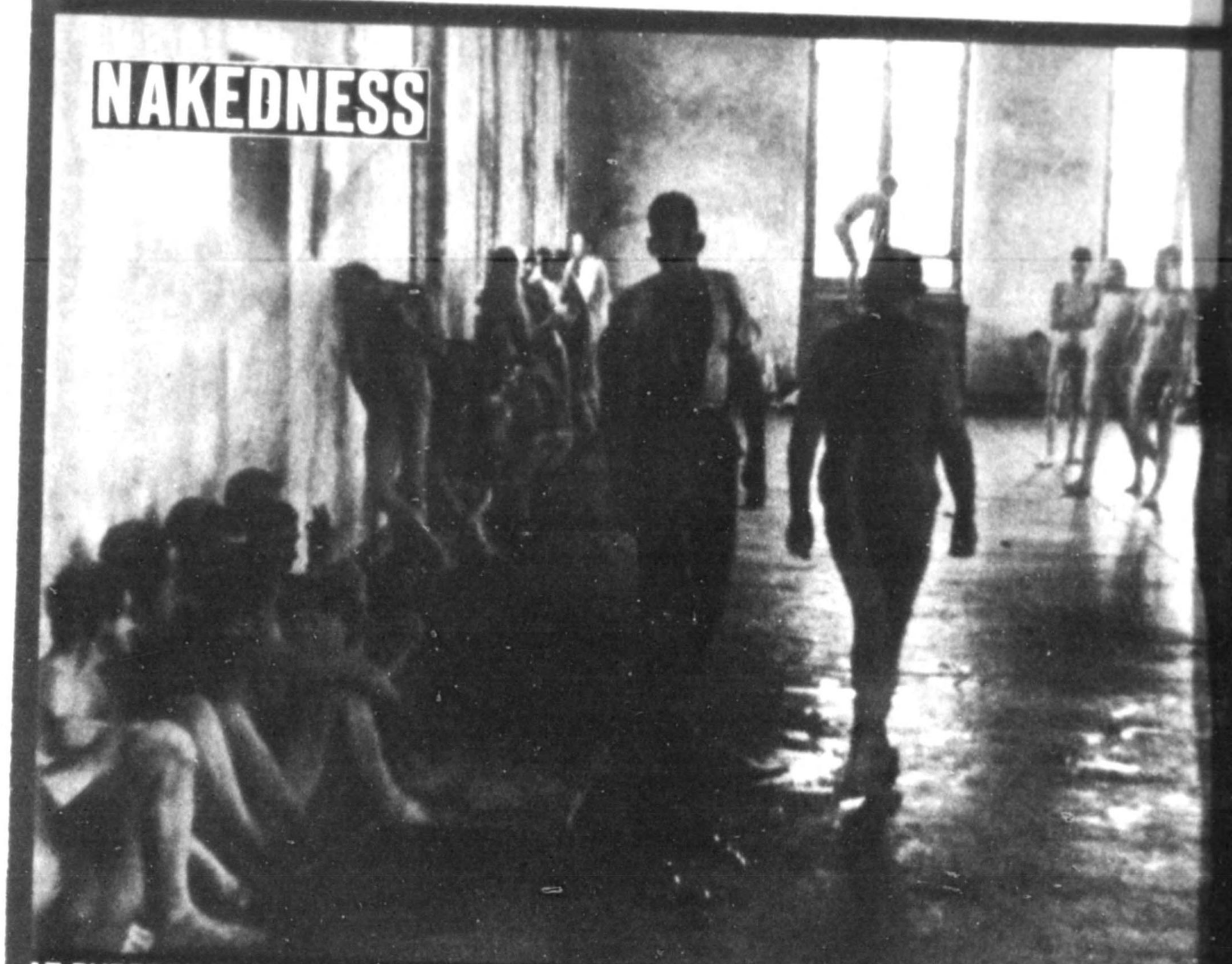
Even within individual states some outstanding superintendents have managed to raise their institutions to a decent level despite low pay scales and heavy overloads. By ingenuity, leadership and hard work some have succeeded not merely in discountenancing beatings and restricting the use of restraints and solitary confinement but in eliminating these relics of the dark ages entirely.

The sad and shocking fact, however, is that these exceptions are few and far between. The vast majority of our state mental institutions are dreary, dilapidated excuses for hospitals, costly monuments to the states' betrayal of the duty they have assumed to their most helpless wards.

Charges such as these are far too serious to be based solely upon the observations of any single investigator. But there is no need to do so. In addition to my own observations in a dozen hospitals, in addition to court records and the reports of occasional investigating commissions, there is now available for the first time a reliable body of data covering nearly one third of all the state hospitals in 20 states from Washington to Virginia, from Maine to Utah. A by-product of the war's aggravation of the long-existing personnel shortage, this data represents the collated reports of more than 3,000 conscientious objectors who, under Selective Service, volun-

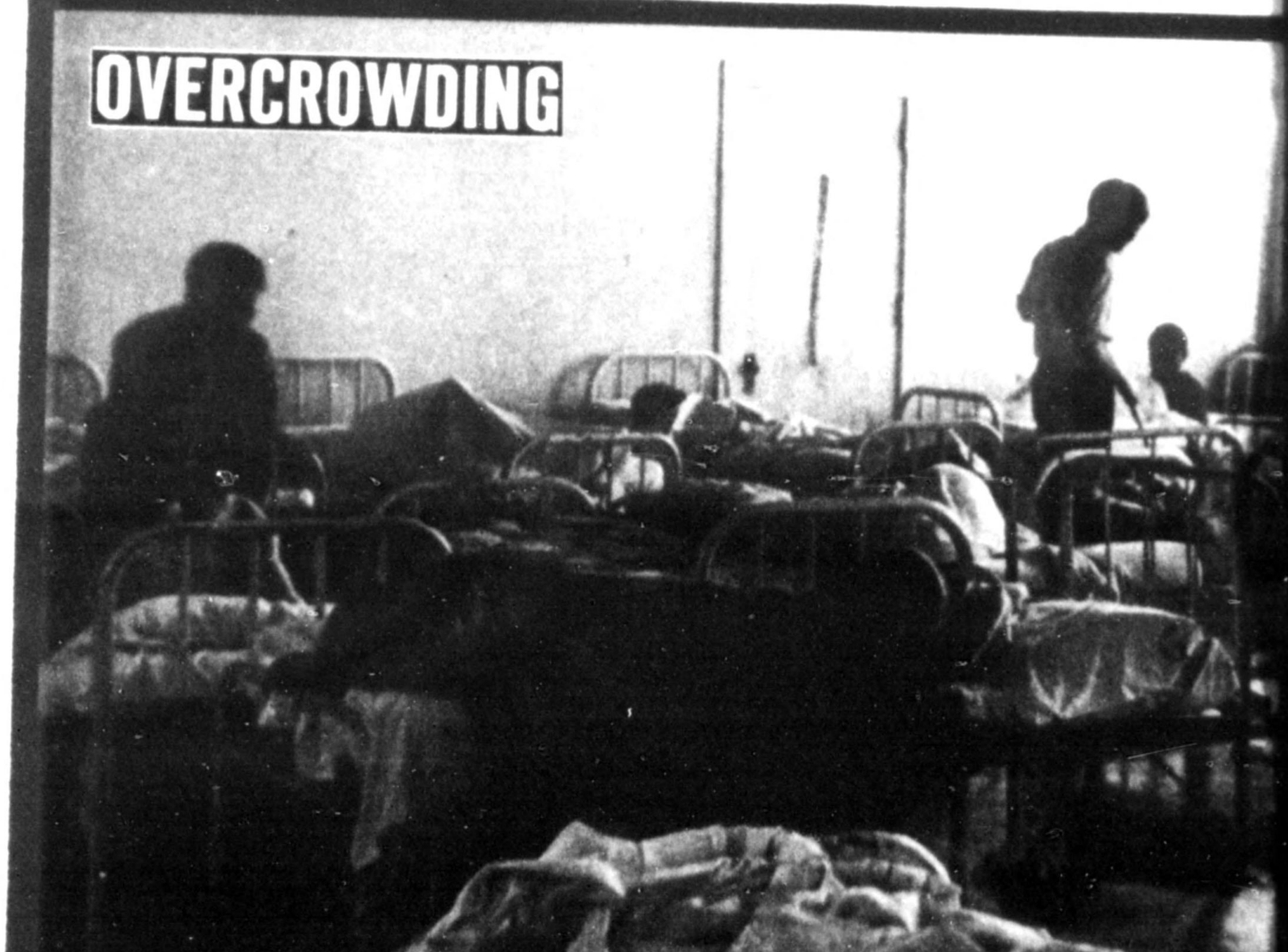
USELESS WORK

NAKEDNESS



AT BYBERRY HOSPITAL NEAR PHILADELPHIA THESE MALE PATIENTS GET NO CLOTHES

OVERCROWDING



AT BYBERRY BEDS ARE JAMMED CLOSE TOGETHER WITH NO CLEAR PASSAGEWAY TO

FORCED LABOR

THESE MALE PATIENTS GET NO CLOTHES TO WEAR, LIVE IN FILTH

ETHER WITH NO CLEAR PASSAGEWAY TO DOOR IN CASE OF FIRE

teered for assignment as mental hospital attendants. The majority are still in service and, with Selective Service approval, these serious young Methodists, Quakers, Mennonites and Brethren have been filling out questionnaires and writing "narratives" for use in the preparation of instructional material for mental-hospital workers.

One may differ, as I do, with the views that led these young men to take up a difficult and unpopular position against service in the armed forces. But one cannot help but recognize their honesty and sincerity in reporting upon the conditions they found in the hospitals to which they were assigned. Supported as they are by other official data, their reports leave no shadow of doubt as to the need for major reforms in the mental-hospital systems of almost every state.

Consider, for instance, the shocking data on brutality and physical abuse of the patients. One report from a New York State hospital reads as follows:

". . . The testimony revealed that these four attendants slapped patients in the face as hard as they could, pummeled them in their ribs with fists, some being knocked to the floor and kicked. One 230-pound bully had the habit of bumping patients on the back of the head with the heel of his hand—and on one occasion had the patient put his hands on a chair, then striking his fingers with a heavy passkey. . . ."

From a state hospital in Iowa comes the following report:

"Then the 'charge' (attendant) and the patient who had done the choking began to kick the offender, principally along the back, but there were several kicks at the back of the neck and one very painful one in the genitals which caused the victim to scream and roll in agony. . . . Something more than 20 kicks must have been administered. Finally he was dragged down the floor and locked in a side room. When I asked the 'charge' how it started, he said 'Oh, nothing. That ———— ought to be killed.' The victim was in handcuffs all the time; had been in cuffs continuously for several days."

From an Ohio state hospital:

"An attendant and I were sitting on the porch watching the patients. Somebody came along sweeping and the attendant yelled at a patient to get up off the bench so the worker-patient could sweep. But the patient did not move. The attendant jumped up with an inch-wide restraining strap and began to beat the patient in the face and on top of the head. 'Get the hell up . . .!' It was a few minutes—a few horrible ones

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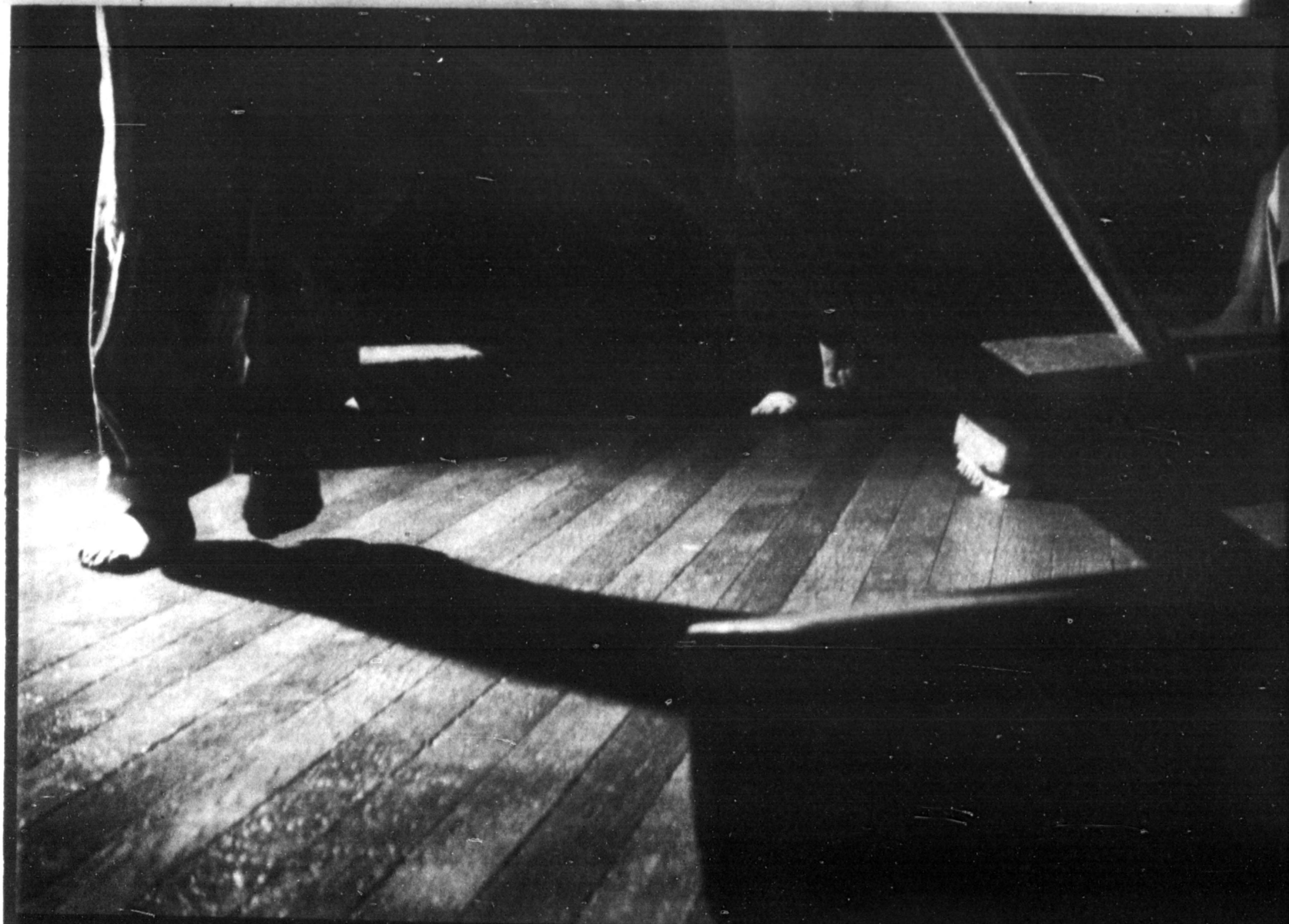

AT MASSILLON OHIO STATE HOSPITAL BAREFOOT PATIENTS POLISH SPLINTERED WOODEN FLOOR IN 1890 BUILDING—A POOR SUBSTITUTE FOR OCCUPA

DING—A POOR SUBSTITUTE FOR OCCUPATIONAL THERAPY

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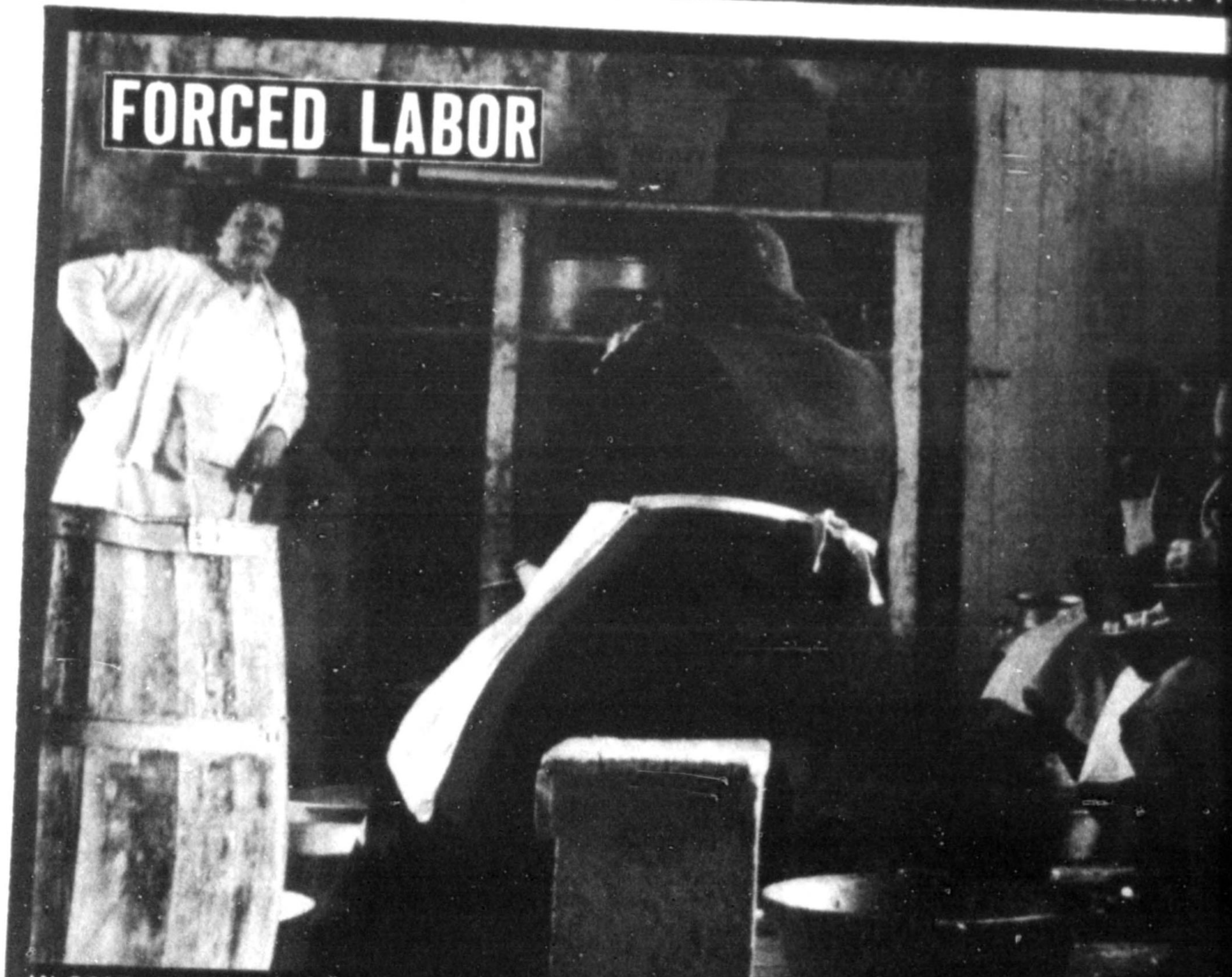

IN COLD, DAMP ROOM AT MASSILLON WOMEN PATIENTS PEEL POTATOES, SUPERVISED B

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AT MASSILLON WOMEN PATIENTS PEEL POTATOES, SUPERVISED BY ATTENDANT AT LEFT

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These are but samples among score upon score of cases described and corroborated in the records of the National Mental Health Foundation. The ultraskeptical may feel that they represent the exaggerated views of impressionable conchies with a moral ax to grind. But this idea is fully refuted by the facts concerning other cases which have broken into the newspapers and reached the courts.

The state hospital at Nevada, Mo. was investigated as a result of the death of a patient, Cordell Humphrey, last July 6. An autopsy performed by Dr. Van Urk of Carthage, Mo. showed that Humphrey had been beaten severely a short time before his death. "There were marks on the arms, legs, chest, abdomen and head, and injuries to the brain that could have caused the death," Dr. Van Urk reported. As a result of this incident Attendant Massey Cloninger was sentenced to five years in the state penitentiary


IDLENESS

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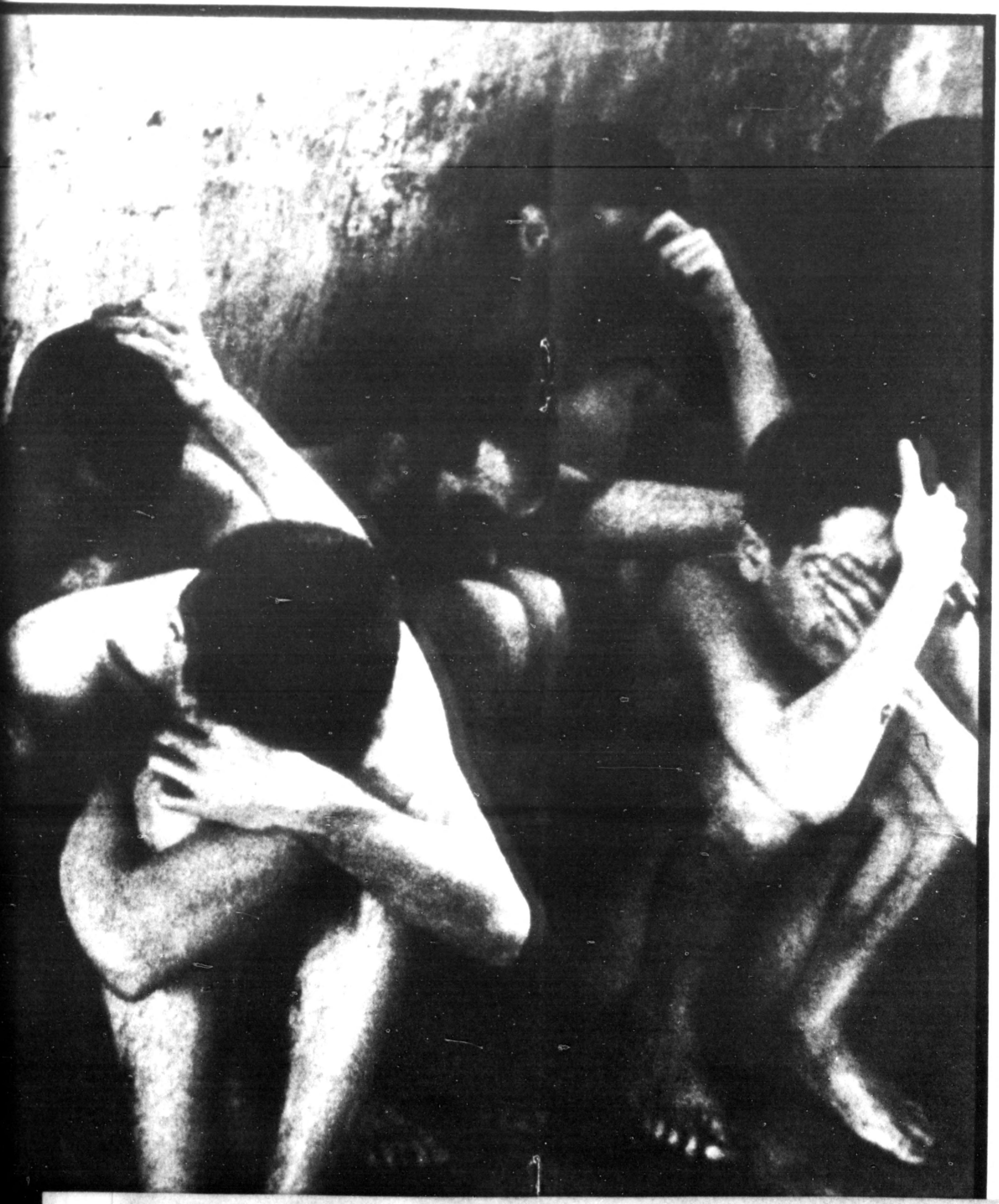

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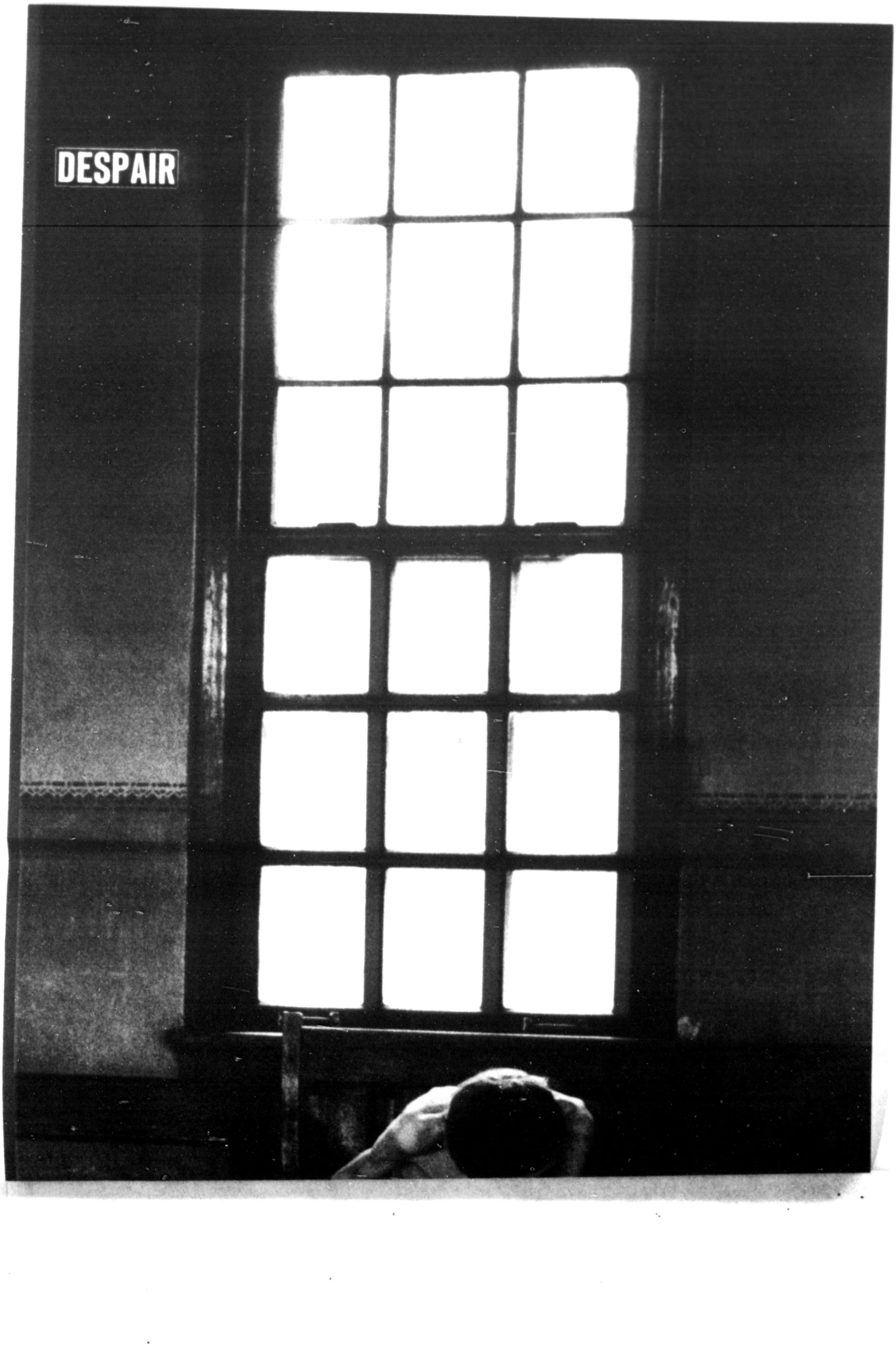
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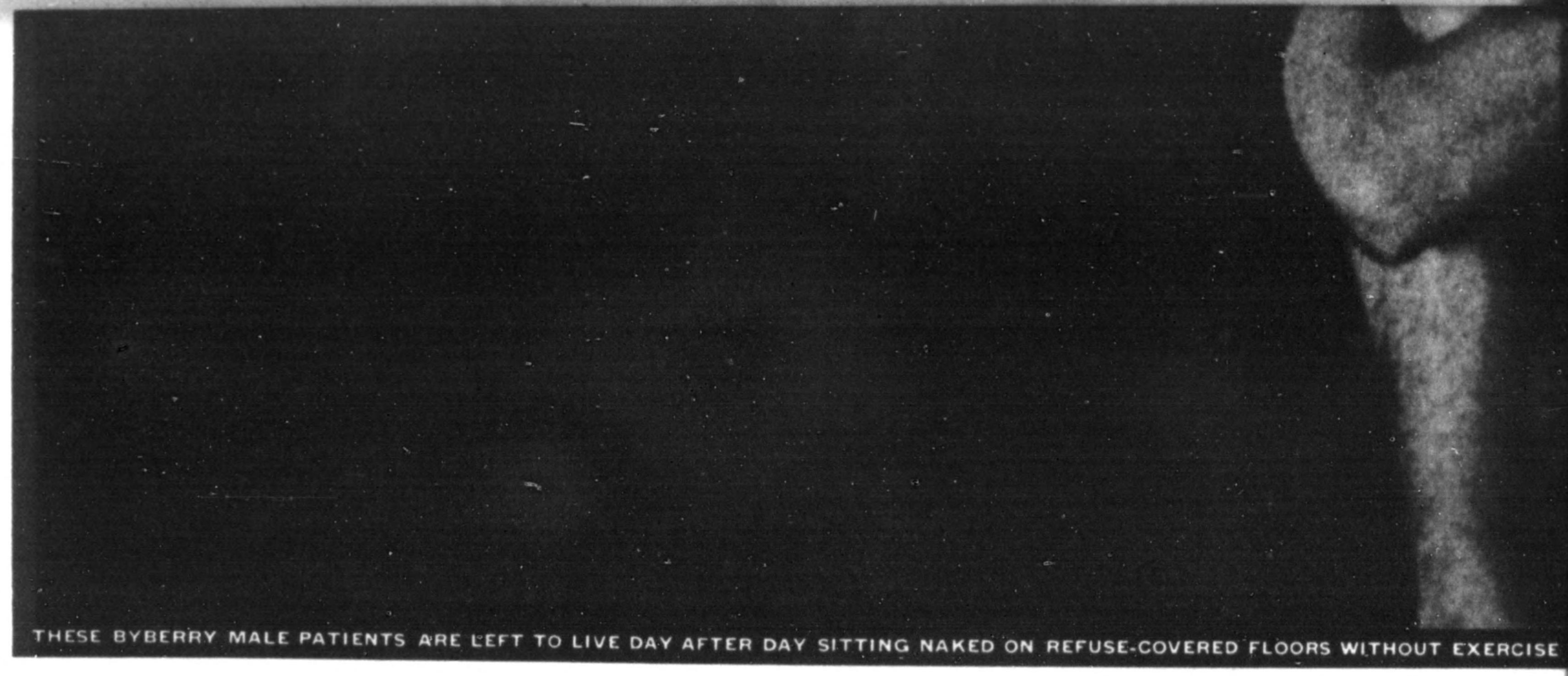

THESE BYBERRY MALE PATIENTS ARE LEFT TO LIVE DAY AFTER DAY SITTING NAKED ON REFUSE-COVERED FLOORS WITHOUT EXERCISE

and another attendant is awaiting trial on charges of assault.

At Hastings, Neb., in February of this year, former State Hospital Attendant William L. Skelton was convicted of assault in connection with the death of Alfred T. Anderson, a patient. Skelton helped hold Anderson down while another attendant beat him with a blackjack.

In 1941 five attendants at Connecticut's Fairfield State Hospital were charged with complicity in two separate beatings of patients, one of whom died. Two of these attendants were convicted of manslaughter and one of assault. Early in 1942 two attendants were arrested for abusing five patients at the Middletown State Hospital and one of the attendants received a jail sentence. As a result the Public Welfare Council and the U. S. Public Health Service made a thorough investigation of all of the Connecticut mental institutions. Yet only last November serious charges of maladministration at the Fairfield State Hospital brought about another inquiry which ended with the resignation of the hospital superintendent.

Hospital administrators do not, of course, countenance beatings in Connecticut or elsewhere. Yet in case after case, instead of bringing criminal charges, they have been satisfied merely to admonish or, at most, discharge the guilty attendant—leaving him free to move on to other states or even to other hospitals within the same state. A typical instance of this sort came to

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light in Cleveland last year when Attendant Aaron Copley was tried and convicted in Municipal Court on a charge of assault and battery upon a patient. Copley contended that he was "being made the goat" and that brutality was commonly practiced in the Cleveland hospital. He submitted charges involving seven separate beatings by three other attendants. When the court probation officer investigated these charges he found that Attendant Hunter, one of those accused by Copley, had a record of previous conviction for arson and had been an inmate of the Veterans Administration mental hospital at Perry Point, Md. Yet despite this record, elicited in a single week by a few letters from the probation officer, Attendant Hunter had had no difficulty in securing and retaining employment at the Cleveland hospital, even after suspicious "accidents" had occurred in his ward while he was on duty. The hospital had never bothered to make even a cursory check of Hunter's character and background.

The fact is that beatings are merely the extreme end product of a system which thrusts upon overworked, poorly trained and shamefully underpaid employes the burden of controlling hundreds of patients whom they fear and despise. Far more frequent than beatings are the endless cruelties involved in the use of restraints. Although some hospitals have managed to dispense with physical restraints entirely and others permit their use only on written order from doctors, the all-too-widespread practice is to leave the decision to tie down a patient or

SIMILAR TREATMENT

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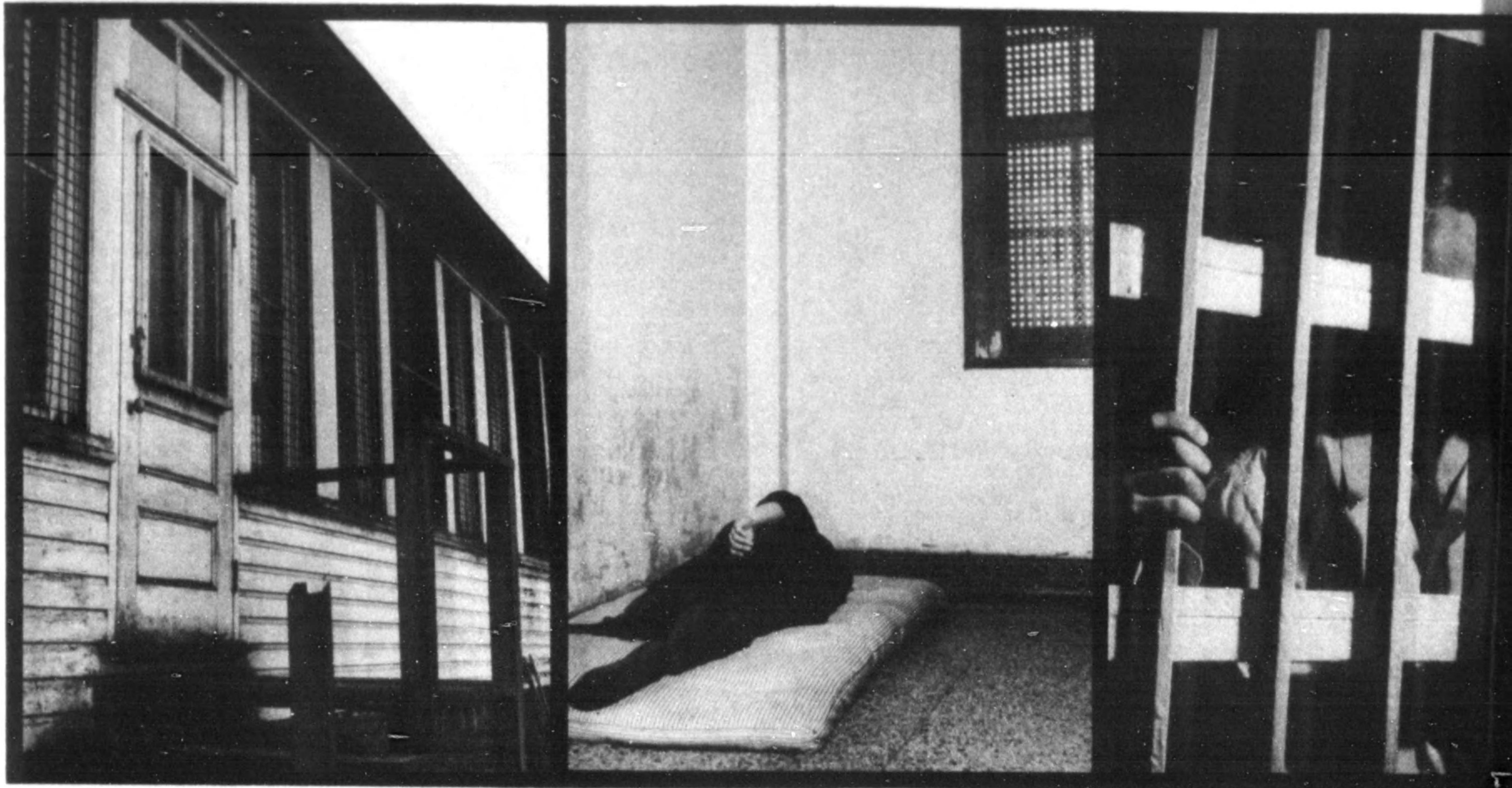

COTTAGE FOR SENILE WOMEN at Cleveland State Hospital is a firetrap, with the exit door locked (*left*). Many patients are lodged in virtually bare cells similar to the one in the center photo. Columbus
houses mental patients until space is available at state m

throw him into solitary up to the harassed and fearful attendant.

The investigators of the Connecticut hospitals in 1942 cited the presence of 16 patients in restraint and 32 in seclusion at Norwich State Hospital in February of that year. Deploring this, they expressed the pious hope that "the use of such measures be materially decreased." Yet in a single month in 1945, according to records cited by two "conchie" attendants, 26 patients in this same hospital spent 6,552 hours in canvas lacings, mittens and sheets. Eighty others spent 13,900 hours in solitary seclusion!

One conscientious-objector attendant, reporting from a state hospital in New York, gave the following account of the way in which restraints are abused. He wrote:

"We have one patient, E. E., who has been in restraint sheets for a period of several months; often he is not even toileted once during the day. . . . Another patient, A. H., has been in a camisole for over a month and the only time it is taken off is once a week for bathing."

In Pennsylvania, the State Bureau of Mental Health has issued repeated detailed orders, ever since 1925, limiting the use of restraints. In theory, under these orders, restraints "should be applied only on written order of a physician and for a specified period." In theory a complete and detailed record on the use of restraint is supposed to be kept.

Yet the notes of a conference of 30 members of the conchie unit at a Pennsylvania hospital in August 1944 read:

from the same unit) illustrates the end results of su
administration of drugs:

"L. was a young man about 25 . . . so quick and
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he made a serious attempt to save the boy. I ma
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OVERWORK BREEDS BRUTALITY

When one studies the almost endless parade
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At Warren, Pa. for instance, the hospital is su
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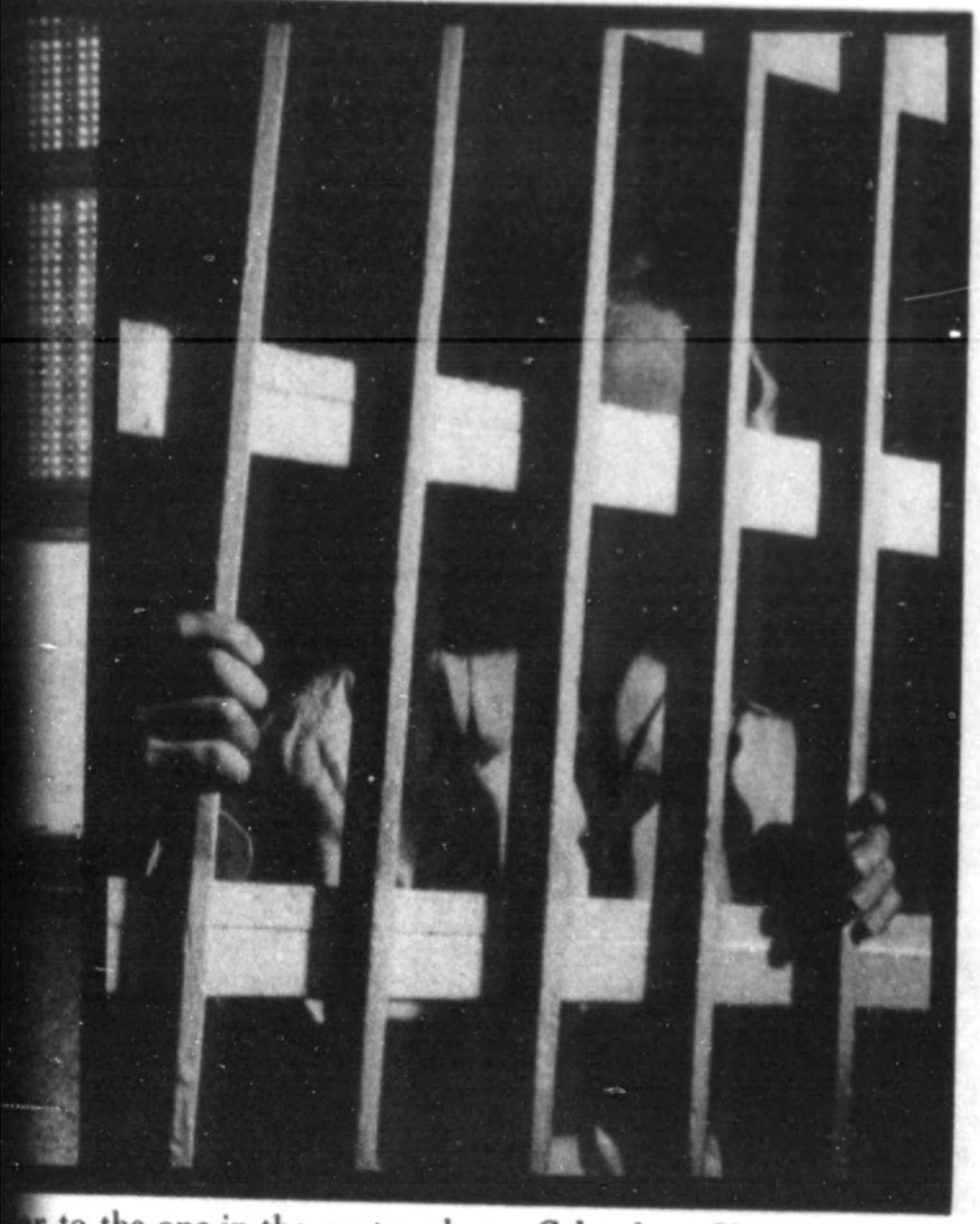

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TUBERCULAR MENTAL PATIENT (*left*) in Cleveland is strapped to his bed. Such devices are often used because of lack of sufficient attendants.

tub and on the patient being bathed, as well as on the attendant doing the bathing."

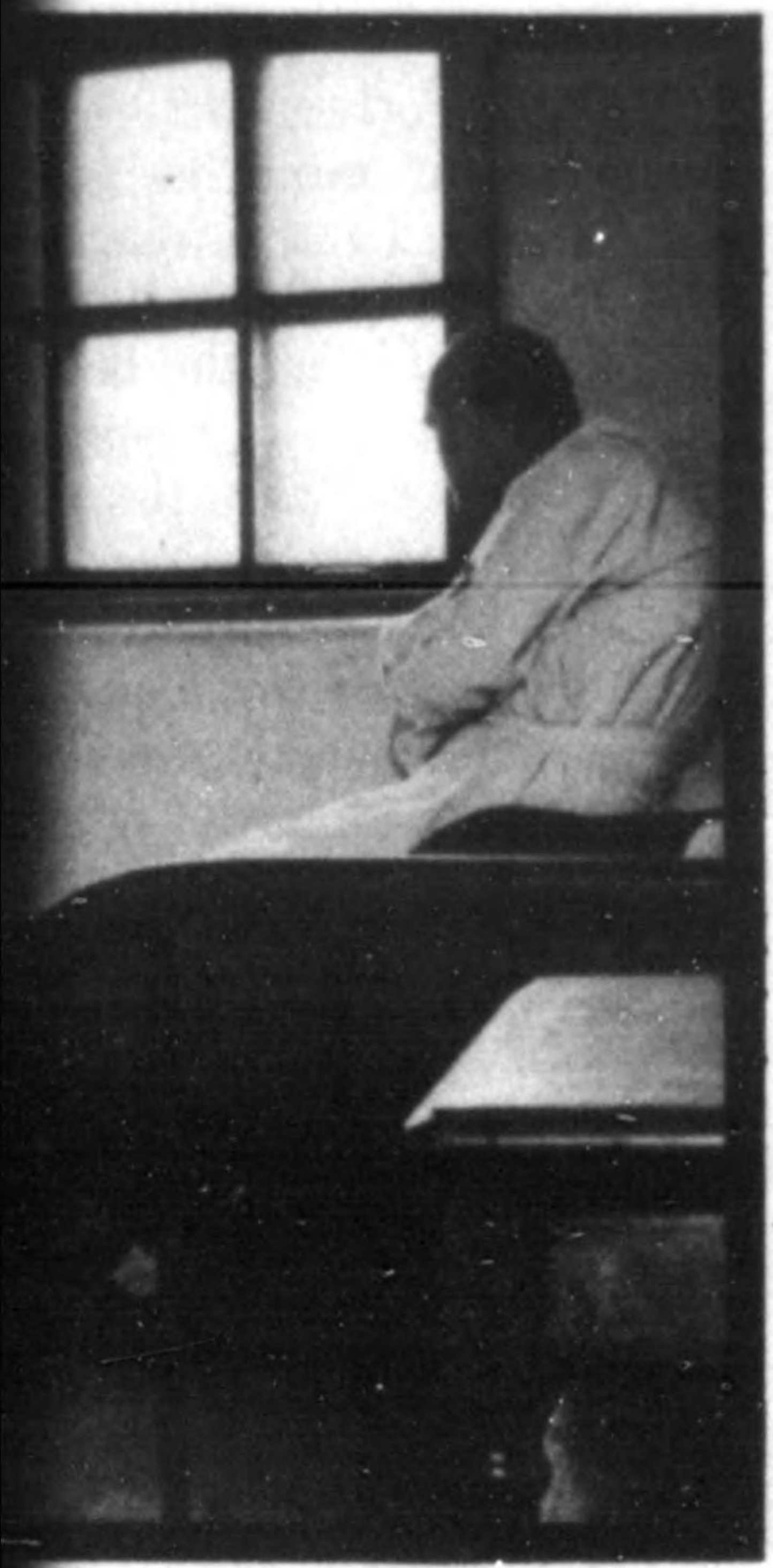
From a New York state institution:

"On Ward 41 we keep the more disturbed and untidy patients . . . who frequently break the windowpanes. During the summer no attempt was made to replace broken panes. When cold weather came there were still no windowpanes put in. For two weeks we attendants called the attention of the supervisor to this condition but [he] merely passed it off as unnecessary, not bothering even to go out to the day room to investigate."

Even the food is skimped. In 1940 the average value of the food consumed by patients in mental hospitals throughout the U.S. was 23.3¢ per day. Some states were trying to feed patients on as little as 17¢ a day and even in such high-cost areas as New York the daily food consumption was only 26.8¢. In most cases these figures include the food raised by patient labor on hospital farms.

Investigators are often fooled by elaborate menus prepared by dietitians and carefully filed in the hospital records. How deceptive these menus can actually be is demonstrated by the records kept by one objector-attendant at a Connecticut state hospital.

One morning in August 1944, when the patients' breakfast menu called for Maltex and soft-cooked eggs, the patients got merely Maltex. That night instead of a menu-listed ration of "macaroni, tomatoes and cheese" their supper consisted of nothing but lima-bean soup. A few days later breakfast was supposed to have consisted of "orange halves, corn meal and scrambled eggs." The patients got only corn meal. For dinner that day they were supposed



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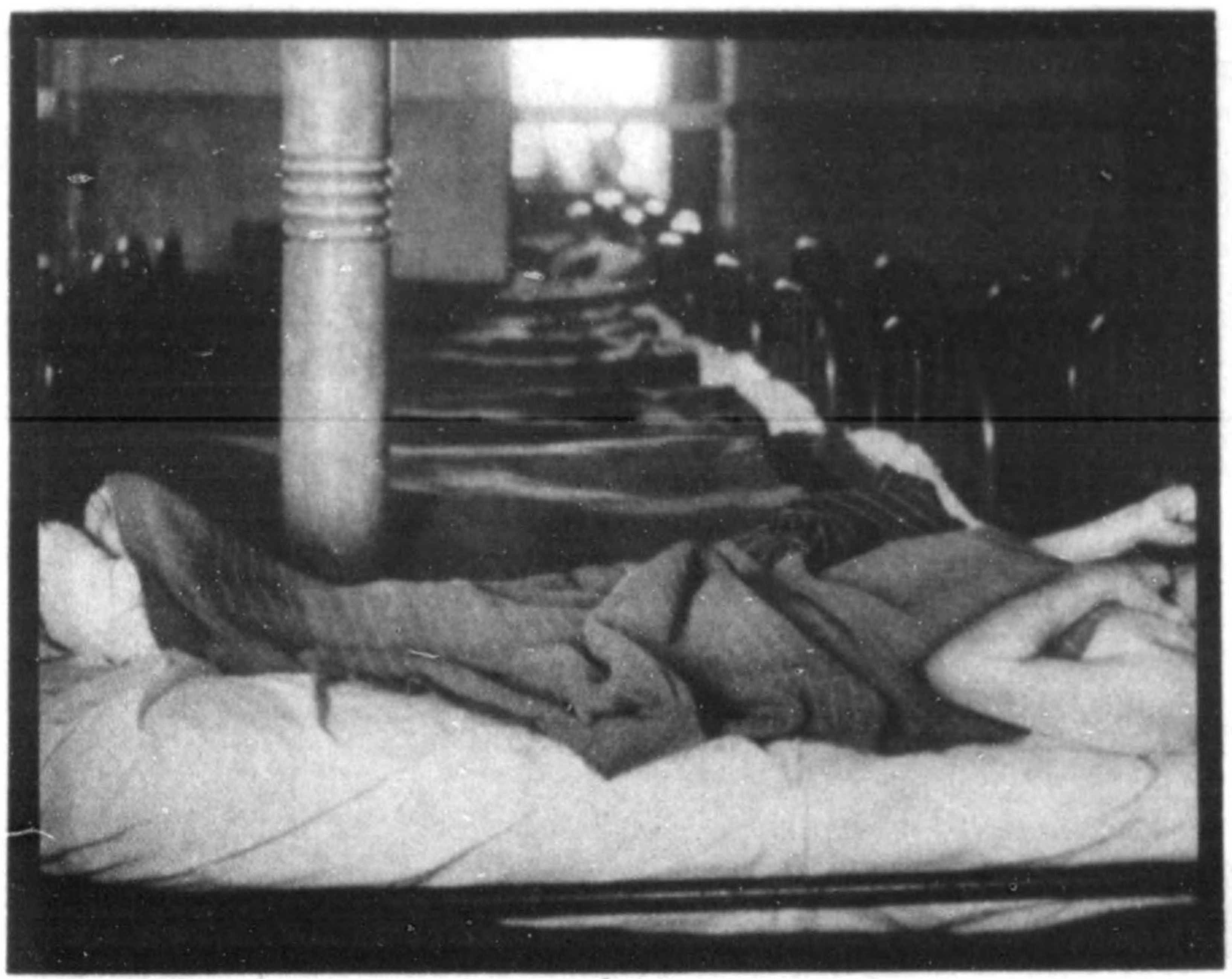

MENTAL PATIENT WITH INJURED LEG has not seen a doctor in four days in Cincinnati's Longview Hospital. Ward was designed as boiler room.

served in the patients' dining room at Warren State Hospital. On only six occasions did it comply with the law. The average bacteria count of this unpasteurized raw milk was 398,100. On three occasions it exceeded 1,250,000 and on one occasion it exceeded 3,200,000!

OVERCROWDING MEANS FEWER CURES

Abuse and the punitive use of restraints, overcrowding, underfeeding and dilapidation might all be condoned if only these hospitals achieved a reasonable standard of treatment and cure. But the fact is that the vast majority of them fall far below the achievements of the few better hospitals and far, far below what could be achieved if cure rather than mere custody were the primary objective.

Annually, in the U. S. as a whole, for every 100 mental patients fewer than 12 are discharged as improved. Even of these, more than 40% have to be readmitted and reconfined, usually within a few months.

The discharge rate tends to fall as overcrowding rises. Again using pre-Pearl Harbor figures, New Mexico, overcrowded by 107.5%, achieves a discharge rate of only 4.1%. Illinois, on the other hand, has only a few hundred more patients than its buildings were designed to hold. Its discharge rate is 15.9%, nearly four times as high as that of New Mexico.

There are eight so-called "special therapies" which provide a good index of the degree to which any hospital attempts to achieve cure or improvement for the large proportion of cases where modern medicine offers hope. In most of the northern and central states all eight of these types of treatment are, at least theoretically, available to the patients. But the figures of 1939, before war same hospital spent 6,552 hours in canvas lacings, mittens and sheets. Eighty others spent 13,900 hours in solitary seclusion!

One conscientious-objector attendant, reporting from a state hospital in New York, gave the following account of the way in which restraints are abused. He wrote:

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Yet the notes of a conference of 30 members of the conchie unit at a Pennsylvania hospital in August 1944 read:

"Sheet restraints are used considerably but *never reported;* the usual practice for the first half day in hydrotherapy (female) is to put patients tautly in restraints with hands above heads, often causing immobility of arms when restraints are removed. . . . Towels are frequently used on both male and female sides for temporary restraint. . . . Cuffs and straps are in general use, in all combinations, partial and complete; sheets are used to tie ankles, necks and chests to beds, benches, chairs. Hands and feet are often observed in swollen condition because of insufficient supervision in such cases."

"Records show an average of 38 or more in restraint; there are some cases when actual number in restraint is greater than the recorded number. Some have been in restraint in B [building] for the seven months that one attendant has worked there; some are in [restraint] on the female side for weeks and months without the doctors seeing them 'because the doctors don't like to go up stairs.' "

In the more "enlightened" hospitals chemical restraints (*i.e.,* drugs) are used to keep the patients under control so that they will be less trouble to the attendant. In theory these drugs can be prescribed only by physicians or registered nurses. In practice they are often sent up to the wards in batches and administered at the discretion of untrained attendants. A case cited by one conchie at another Pennsylvania state hospital (and corroborated by another

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From a New Jersey state hospital, an attendant writes:

"At its worst, which we see daily, the plates take on the appearance of what usually is found in most garbage cans. . . . I have seen cole-slaw salad thrown loose on the table, the patients expected to grab it as animals would. . . . Tables, chairs and floors are . . . many times covered with the refuse of the previous meal."

The inadequacy of the patients' food is often aggravated by the assignment of the finest foods to the hospital staffs. The dinner menu for the doctors at a Pennsylvania state hospital on a Tuesday in August 1945 consisted of "prime rib roast beef with gravy, broiled potatoes, roast corn on the cob, bread (white, whole wheat, rye or raisin) with butter, salad of cucumbers, lettuce and celery, apple-apricot pie and coffee, tea, iced coffee, iced tea, or milk." On the same day patients in several buildings got "hard-boiled eggs, lima beans, beets, white bread without butter and milk or black coffee."

Pennsylvania state law requires that all milk except Grade A be pasteurized. Grade A milk is required to have a bacteria count of fewer than 50,000 per cubic centimeter. On 22 separate occasions from January 1943 to December 1944 tests were made of the milk

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onsisted of nothing but lima-
t was supposed to have con-
nd scrambled eggs." The pa-
that day they were supposed
with raisins." They actually
oes. For supper they were
slaw. They actually got bean

an attendant writes:
the plates take on the appear-
ost garbage cans. . . . I have
n the table, the patients ex-
. . Tables, chairs and floors
refuse of the previous meal."
ood is often aggravated by the
ospital staffs. The dinner menu
ate hospital on a Tuesday in
roast beef with gravy, broiled
d (white, whole wheat, rye or
s, lettuce and celery, apple-apri-
ed tea, or milk." On the same
"hard-boiled eggs, lima beans,
and milk or black coffee."
hat all milk except Grade A be
ed to have a bacteria count of
eter. On 22 separate occasions
44 tests were made of the milk

jective.

Annually, in the U. S. as a whole, for every 100 mental patients fewer than 12 are discharged as improved. Even of these, more than 40% have to be readmitted and reconfined, usually within a few months.

The discharge rate tends to fall as overcrowding rises. Again using pre-Pearl Harbor figures, New Mexico, overcrowded by 107.5%, achieves a discharge rate of only 4.1%. Illinois, on the other hand, has only a few hundred more patients than its buildings were designed to hold. Its discharge rate is 15.9%, nearly four times as high as that of New Mexico.

There are eight so-called "special therapies" which provide a good index of the degree to which any hospital attempts to achieve cure or improvement for the large proportion of cases where modern medicine offers hope. In most of the northern and central states all eight of these types of treatment are, at least theoretically, available to the patients. But the figures of 1939, before war emergencies arose, indicate that North Carolina offers only two of the eight; South Dakota, Vermont, New Mexico, Arizona and Nevada offer only three; Alabama, Utah and North Dakota offer only four.

In some hospitals the shortage of personnel and the patient overload have progressed to a point where physicians make little pretense of treating any large proportion of the patients. The vast majority of patients get whatever treatment they do receive from unskilled and untrained attendants. A Mental Health Foundation report from an Iowa state hospital reads:

"Attendants give medications constantly and without doctor's signature, on oral orders only. They decide restraint problems and no reports are made. They receive no training. There are *no* nurses in this hospital."

A similar report from another Iowa hospital says:

"There is no systematic review of classification and parole-eligibility by the staff. Such review was begun a year ago but given up as hopeless within a few weeks. . . . Many patients are good parole prospects but are not considered except upon request of relatives . . . no longer any special diets for diabetics. Such diets used to be prepared some time ago but have been discontinued. Diabetics eat the same meals as other patients now."

Despite work loads that would break the strongest men, many

IN A MODERN HOSPITAL at Youngstown, Ohio a woman psychologist tests a patient. Youngstown has new equipment, many well-trained attendants.

state hospital physicians labor to the point of exhaustion in a sincere effort to do their very best under discouraging circumstances. In the many hospitals I have visited I have seen numerous men and women physicians doing jobs of truly heroic proportions. At Dayton, Ohio a 73-year-old woman physician has come out of retirement to work long hours, often visiting her patients in a wheelchair.

TOO MANY DOCTORS ARE INCOMPETENT

Others, however, are incompetents, alcoholics and psychotics who could hold no position in well-run institutions where cure is the objective. All too often the end result can be described in the terms used in a report from an Indiana state hospital:

"During my three months there I never saw the ward doctor give any but a cursory physical examination. He usually would stop but for a moment at the bedside of new patients. He was nicknamed 'the Butcher' by the nurses, after his manner of lancing boils. He seldom came to the ward to declare an expired patient dead. He would be called on the phone by a nurse when a patient was thought to have expired. Usually he would say 'Oke' and that would be the end of it. On outwards, patients are prepared for and sent to the morgue without ever a doctor appearing on the ward."

From a Pennsylvania state hospital a report reads:

"On one occasion a young patient with a fractured hip was sent to us (2-West, Male Infirmary) and we got him up into a wheelchair for several days, not knowing what was wrong with him. No doctor corrected our mistake until five weeks later."

From Utah comes the report:

"A patient became ill and his rectal temperature was found to be 105.4. The doctor who was called replied, 'He gets a high tem-

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THE SCANDAL GROWS

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stigma of court commitment and incarceration in an "insane
lum." The first of these was opened last November at Youngs
with a capacity of 80 patients and a staff of 60, including two
sicians, a psychologist, two social workers and 14 graduate nu

Intensive treatment of this sort is expensive. It costs $6 a
opposed to $1.20 a day in Ohio's large and essentially cust
mental institutions. But it produces dramatically effective re
In the first three months of the Youngstown Hospital's operat
89 patients were discharged after an average stay of only six we
Of these 71 were discharged back to their homes as "improv
and capable of at least a trial at adjustment to life in the ou
world. Only 18 were sent on to other institutions.

The gain to the state is obvious. For something less than $30
spent on six weeks of intensive treatment—the state receiv
high proportion of useful, economically productive citizens, w
the custodial institutions, harboring identical cases, spend as m
or more per patient at their deceptively cheap daily rate and, in
end, fail to restore the majority of these citizens to society.

In addition to these small intensive-treatment hospitals, O
has acquired hundreds of new beds since the reform movem
started and has thousands more under, or awaiting, construct
A strong drive is under way to acquire new personnel and—e
more important—to train new help so that they can functio
medical personnel rather than as keepers. Many of the outstan
sadists and incompetents of the old regime have been dismis
abuse and mistreatment of patients is no longer tolerated c
placently.

Yet the leaders of Ohio's mental-hospital reform moveme
both within and outside of the administration—are by no m
satisfied with the progress that has been made. Their principa
ficulty centers around the pitifully low pay of attendants, nu
and physicians and the impossibility of securing adequate perso
to work 12-hour days for such small wages. Here, up to now,
have been stymied for lack of appropriations.

But they are carrying on the fight. Under the leadership of
Sharpe the newly formed Ohio Mental Hygiene Association
become a rallying point for everyone interested in hospita
provement. Governor Lausche has promised to press for fund
additional personnel and for a change-over to the eight-hour
If these gains—plus substantial salary increases all the way

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the line—can be wrung out of what has been a reluctant and penny-pinching legislature, Ohio will be well on the way to the leading position in the care of the mentally sick which the state once occupied 50 years ago.

For the rest of the country the Ohio experience demonstrates an effective technique through which reform can be achieved. It is no easy formula to follow. It requires years of hard work and the intense interest of at least a few leading members of the community. But spark-plugged by understanding and dynamic leaders and properly presented to the people, a hospital reform movement can sweep any state—just as it has Ohio. For what happens to the mentally sick in our present hellhole hospitals is not the sad experience of some other fellow. Every minister, every doctor and every leader of any community organization knows that mental illness can strike down members of his immediate circle. Given the facts and given leaders of the caliber of Sharpe or Lerch, the people of any state will rally, as have the common people of Ohio, to put an end to concentration camps that masquerade as hospitals and to make cure rather than incarceration the goal of their mental institutions.

REFORM DRIVE in Ohio is led by Dr. Dores R. Sharpe (*left*) of the Cleveland Baptist Association, shown here conferring with Governor Frank Lausche.

PICTURE CREDITS

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Such instances of callousness and incompetence—and the records are replete with hundreds more—cannot, of course, be excused in men licensed as physicians and pledged to the Hippocratic oath. Yet the major burden of blame must be placed elsewhere than upon physicians' shoulders when reports such as this one from a Rhode Island state hospital are considered:

"After much persuasion our ward doctor finally examined a patient suspected of having tuberculosis and sent him eventually to the sanitarium. The patient died two days later of active tuberculosis. The doctor had far too many patients to handle. He was responsible for 550 at the hospital plus some 200 men at the state prison."

As evidence mounts up one is led, inevitably, to the question, "Can things like this ever be corrected?" Fortunately, the answer is "Yes," or rather, "Yes, but it takes hard work." For in the state of Ohio, where conditions were as bad as anywhere in the U.S., a major reform movement is now under way.

It started in 1943 when a group of conscientious objectors stationed at Cleveland State Hospital interested two leading Cleveland citizens, the Rev. Dr. Dores R. Sharpe, executive secretary of the Cleveland Baptist Association, and Walter Lerch of the Cleveland *Press*. Before these men the conchies laid a stack of affidavits

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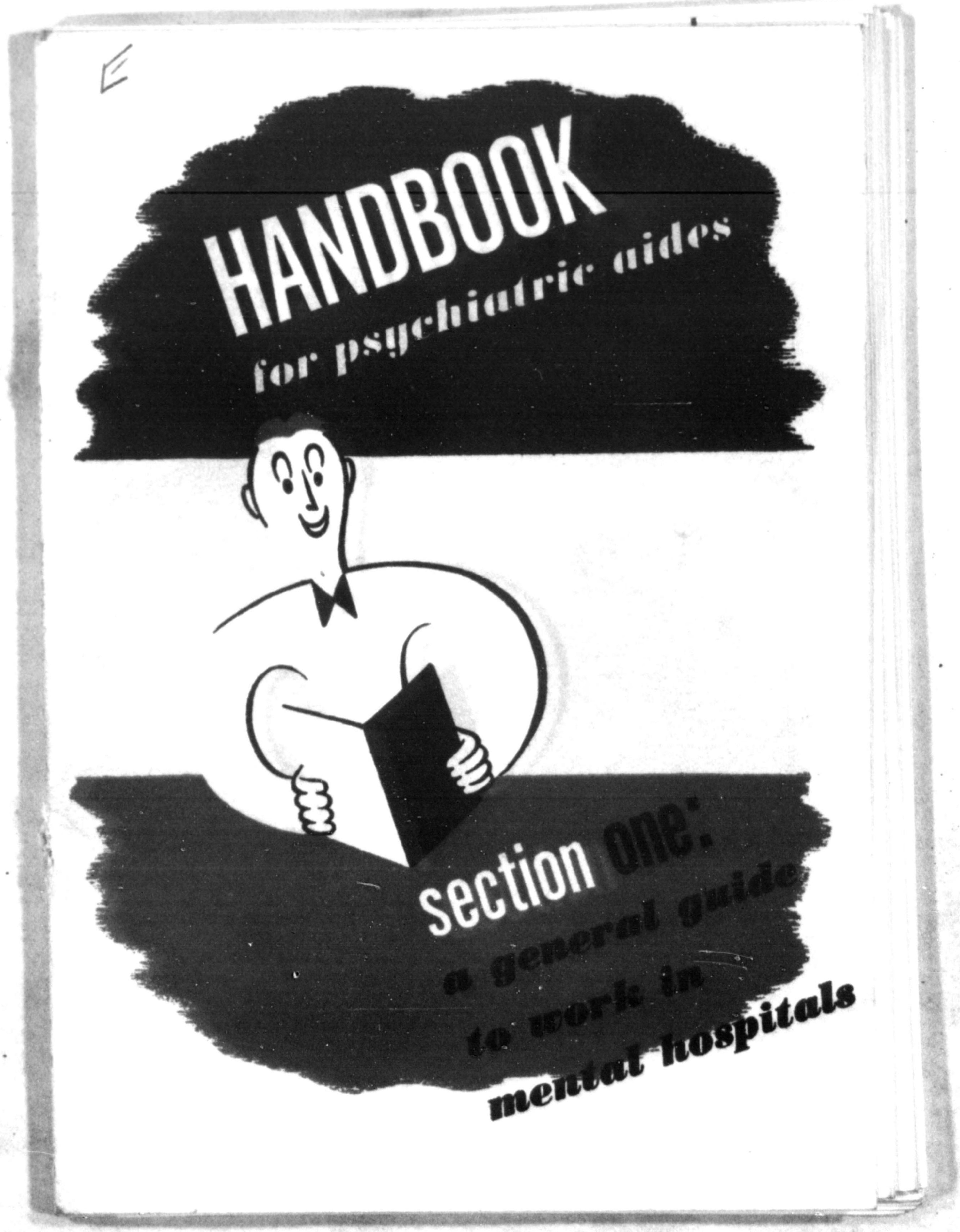

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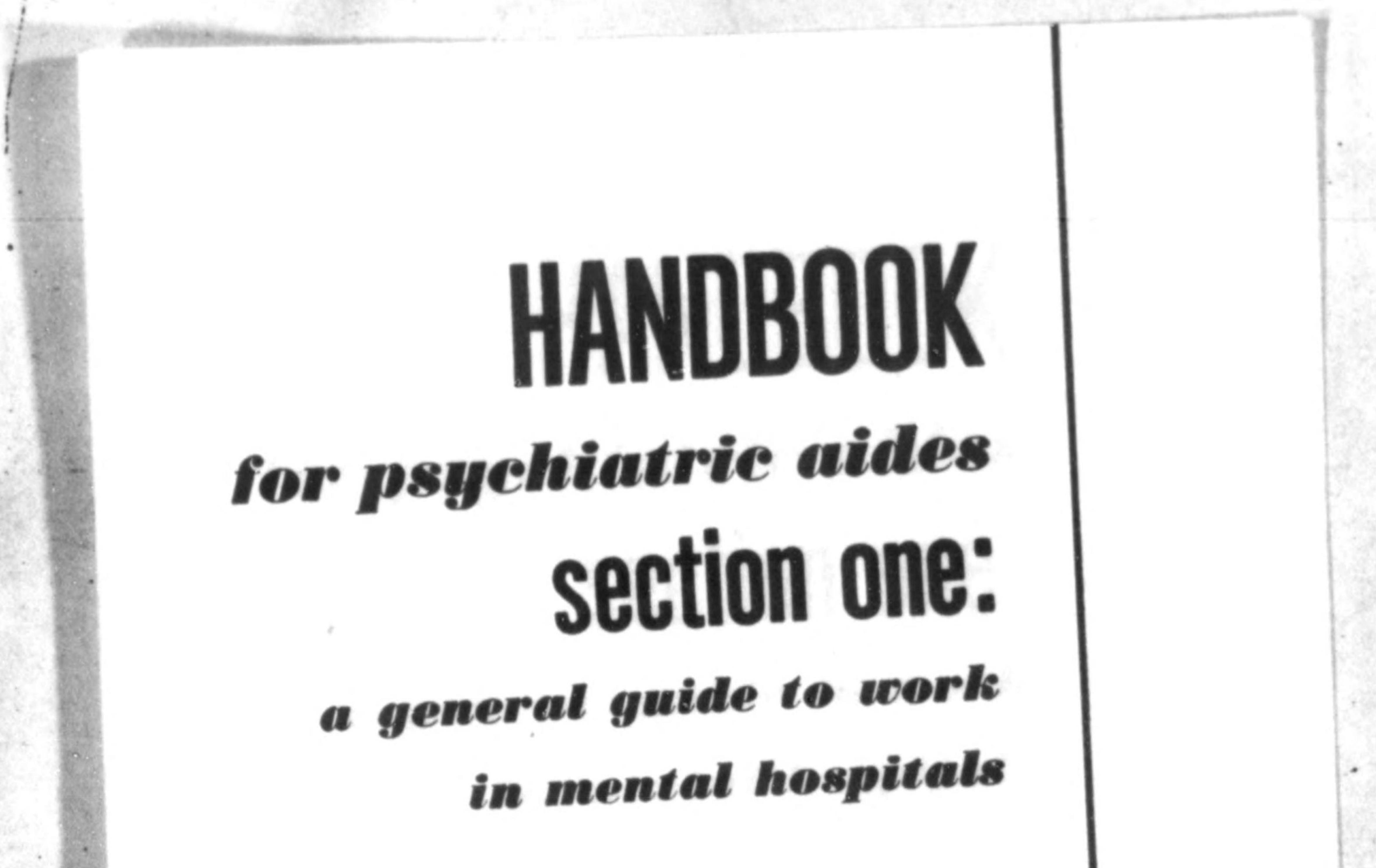

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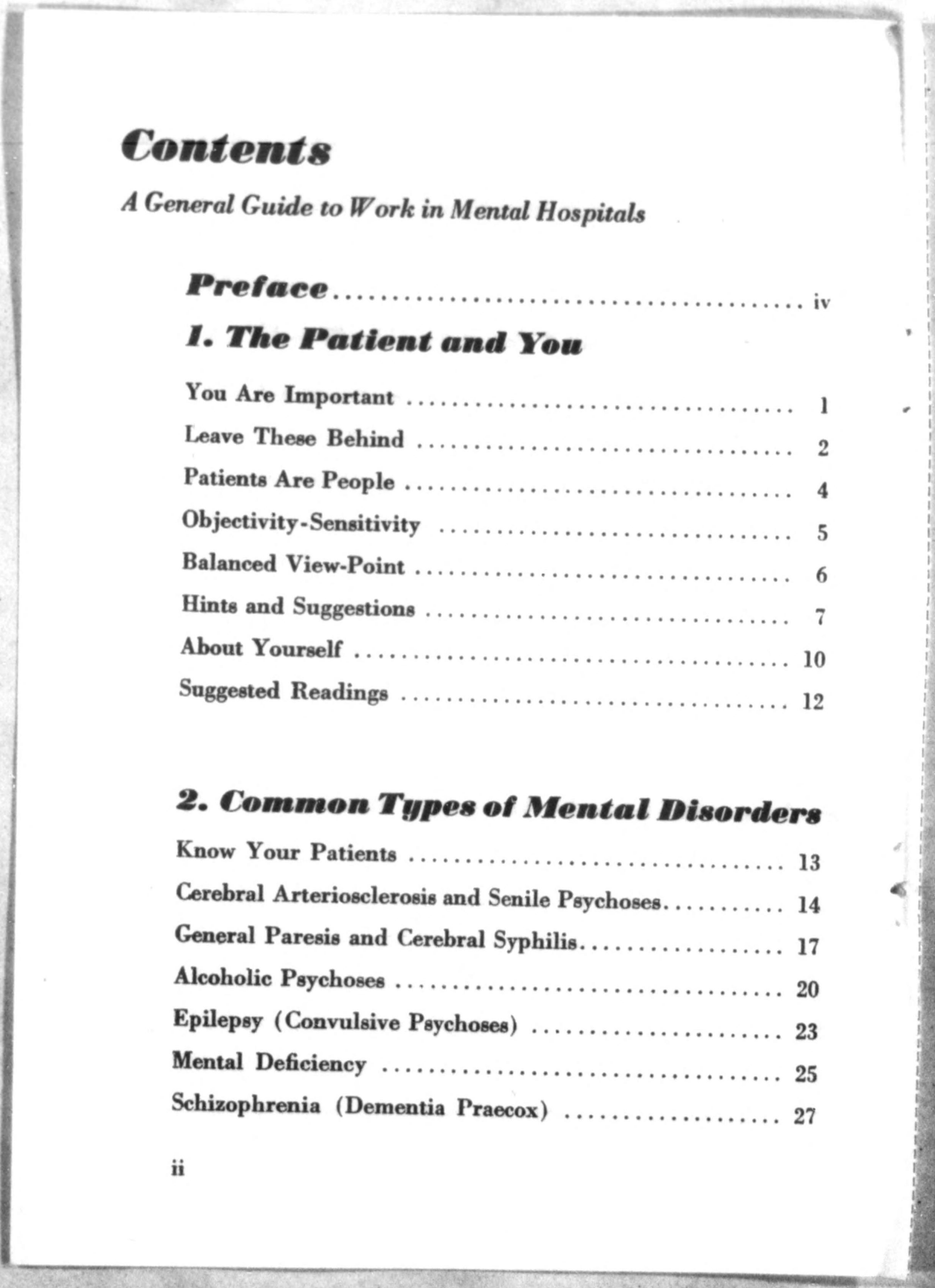

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