HISTORICAL SURVEY OF ATTENDANT-NURSES TRAINING IN MICHIGAN

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ABSTRACT

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Attendant-Nurses have been responsible for the direct care of the institutionalized mentally retarded since the establishment of the Michigan Home for the Feebleminded and Epileptic. They have been responsible for training assigned groups of the retardates in fundamental habit behaviors such as bathing, eating, dressing and toileting. Also, they have been expected to participate in the development of speech, language, play, obedience, moral standards and other behaviors essential to the social acceptance of the individual. The Attendant-Nurse has been identified as the parent surrogate of the institutionalized retardate. Time and again, the literature has identified the Attendant-Nurse as the most significant adult in the life of the institutionalized retardate.

Despite numerous acknowledgements of the important role played by the Attendant-Nurse in the care and training of the mentally retarded in institutions they are hired without experience or training. At the present time, the Michigan Civil Service Commission requires that they be eighteen years old, have an eighth grade education and

an average intellectual level. They hold low status positions and receive the lowest pay.

From the beginning of institutions for the retarded in Michigan to the present the need for training for the Attendant-Nurse has been constantly expressed by those in authority but never more than partially accomplished.

Because of the foregoing paradox, this historical survey has been undertaken with the expectation that documentation of the futile attempts at training, if brought to the attention of concerned officials, could result in more meaningful Attendant-Nurse training programs.

Information about institutions for the retarded and the training of Attendant-Nurses was obtained from institutional files, the State Library, Lapeer and Lansing newspapers, the Michigan Historical Commission's Archives as well as from publications such as the Journal of Insanity.

The survey is divided into four distinct eras as follows:

1. Period prior to establishment of the Michigan Home for the Feebleminded and Epileptic.
2. Period of management of institutions by independent governing board (1895-1922).
3. Period of Michigan Hospital Commission (1923-1944).
4. Period of Department of Mental Health (1945 to date).

There is contained in the individual chapters a brief description of the prevailing thoughts and attitudes in regards to the mentally retarded; comments about conditions within institutions during the era

and a discussion pertaining to the methods and attitudes about the training of the Attendant-Nurse.

The survey indicates that there has been a continually decreasing interest in the training of the Attendant-Nurse as the control of the institutions has become more remote; that is, the independent board of trustees and the superintendent of the early era had a far greater concern and devoted more attention and effort to this training need than is evident at the present time.

Another finding is that the training of Attendant-Nurses in institutions for the mentally retarded failed to keep pace with the continually improving training of nurses in general nor was there any great effort made to meet training standards set by legislation concerned with nursing practice. At the time the original Michigan Nurse Practice Act was passed the Attendant-Nurse training being conducted at Lapeer was adequate for gaining licensure. At this time the training received by Attendant-Nurses in the Michigan institutions for the mentally retarded is not sufficient for gaining any type of nursing license.

The last chapter is concerned with implications which indicate that the attempts at inservice training of Attendant-Nurses in institutions have been quite unsuccessful. However, newly established community college programs for the technical training of mental health workers will enable institutions for the mentally retarded to hire people with adequate training to fill Attendant-Nurse positions.

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CHAPTER I

INTRODUCTION

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Since the first institution for the mentally retarded was established in Michigan Attendant-Nurses have been responsible for the direct, twenty-four hour daily care of the impaired residents. They have been responsible, with minimal guidance, for training an assigned group of the handicapped in the fundamental habit behaviors such as bathing, eating, dressing, toileting, and so forth. Additionally, they have been expected to participate in the retardates' development of speech, language, play, obedience, moral standards and other behaviors essential for social acceptance. Many times the Attendant-Nurse has been identified as the parent surrogate of the institutionalized and with ample justification. Time and again, in the literature concerned with institutions, it has been stated that the Attendant-Nurse is the most significant adult in the life of the retarded, the person who has the most detailed and intimate knowledge of the impaired individual's behavior.

Despite the numerous acknowledgements of the important role played by Attendant-Nurses in the care and training of the mentally retarded they are, and have been for seventy-eight years, hired without training or experience. At the present time the Michigan Civil Service Commission requires that persons aspiring to the position be at least eighteen years old, have an eighth grade education and

an average intellectual level. Within institutions the Attendant-Nurse occupies a low status position among the professionals and para-professionals engaged in caring for the retarded populations and they also receive the lowest salaries.

From the era of independent management of the Michigan Home for the Feebleminded and Epileptic by a Board of Trustees to the present day centralized control of institutions by the Michigan Department of Mental Health the need for extensive training of Attendant-Nurses has been constantly expressed by those in authority but never more than partially accomplished.

With an awareness of the foregoing paradox, this survey has been undertaken with the expectation that a concise historical documentation of the continual futile attempts at training, if brought to the attention of concerned officials, could result in more meaningful Attendant-Nurse training programs. Such an attainment would not only benefit the institutionalized retardates but would provide the parents of these unfortunates with great solace and the community at large with more effective habilitative and rehabilitative services for the mentally retarded.

Throughout the survey that follows terminology has been used in regards to nursing and mental retardation that may be confusing to some readers unless explained because effort was made to use terms that were consistent with the era being considered. Thus a brief explanation of terminology is presented.

NURSING TERMS--For years prior to the enactment of the Nurse Practice Act, hospitals had training schools for nurses and those who successfully completed the course were called Graduate Nurses to

differentiate them from Student Nurses who were still attending classes. In general hospitals persons, usually male, who assisted with the care of the sick, and received little or no formalized training were known as Orderlies. In mental hospitals and institutions for the mentally retarded the term Attendant was used to identify personnel who had not been trained at a level equal to the Graduate and/or Registered Nurse.

This hierarchy of nurses continued until recently when first the Licensed Practical Nurse and then the Licensed Psychiatric Attendant-Nurse gained status by recognition in revisions of the Nurse Practice Act. Both practice nursing with a lesser degree of specialized skill, knowledge, education and training than the Registered Nurse and must perform such acts under the direction of a Licensed Physician, a Licensed Dentist or a Registered Nurse. The Licensed Practical Nurse provides care for, treats and observes the ill, injured and infirmed while the Licensed Psychiatric Attendant-Nurse cares for the mentally ill and the mentally retarded.

With the advent of the Michigan Civil Service the Attendant became known as the Attendant-Nurse. In other parts of the country they are called Psychiatric Aides, Psychiatric Technicians and Mental Health Technicians.

MENTAL RETARDATION TERMS--At the time of the establishment of the first institutions for the intellectually impaired those admitted were considered to be of one functional level and were called idiots. However, it was soon evident that among the idiots were those who could learn and others who failed to respond to instruction. The learners were initially called high grades or imbeciles and the

non-learners were referred to as low grades or idiots. With the realization that the intellectually impaired were of two levels the group as a whole were called feebleminded.

Wide spread use of intelligence tests in the early days of the present century revealed additional individuals, previously unrecognized, with sub-average intelligence. These persons, named morons functioned at a behavioral level higher than the idiot and imbecile, in fact, their major area of maladjustment was their inability to function adequately in the academic environment.

With the realization that some students in community schools were unable to learn because of intellectual deficits, educators became involved with the problem. Teachers introduced more functionally related terminology naming the moron, educable; the imbecile, trainable; and the idiot, custodial.

Although feebleminded remained the legal term for the intellectually impaired until replaced by mentally handicapped at mid-century, the name mentally deficient gradually became the preferred designation as it was accepted that pathological conditions contributed to intellectual inadequacy. As prevailing thought regarding etiology accepted again the contribution of environment to mental impairment the presently used mentally retarded became the name of choice.

Since mid-century the three level functional classification of the mentally retarded, namely, educable, trainable and custodial has expanded to four levels to conform to standard deviations below the mean in the normal distribution of intelligence. A mildly retarded individual has an intelligence quotient that is two to three standard deviations below the mean and has the potential for independent

socio-economic adjustment as an adult. This is approximately equal to those who were formerly called educable. Second is the moderately retarded who has an intelligence level minus three to four standard deviations below the mean, was formerly considered trainable and as an adult will probably be socio-economically semi-independent. Severe retardation is consistent with an intelligence that is four to five standard deviations below mean, will at best reach a semi-dependent level of adult socio-economic adjustment and was previously called custodial. An intelligence quotient five or more standard deviations below the mean is termed profound mental retardation and will be a totally dependent individual throughout life.

CHAPTER II

PERIOD PRIOR TO INSTITUTIONS FOR THE RETARDED IN MICHIGAN

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There is no date in history which can be used to indicate the end of the Renaissance and the beginning of the era in which mans interest in the freedom and well being of his fellow man was awakened. The United States became a democracy in 1776. Pinel removed the shackles from the unfortunate at the Bicetre in Paris in 1792 and inaugurated psychiatric reform. The establishment of the first successful school for idiots by Sequin in 1837 is a significant date in the history of mental retardation.

Prior to the time of Pinel's action, "criminals, chronic invalids, paupers and mental suffers (the insane and idiots), were all herded together at the Bicetre and Saltpetriere and treated alike. The buildings were untenable, the cells were narrow, cold and dripping, unlit and unventilated; and furnished with a litter of straw, which was rarely changed and often infested with vermin. Men crouched there covered with filth; in hideous lairs in which one would have hesitated to confine a beast."[1] The physically and mentally handicapped dwelling there were at the mercy of brutal keepers who were for

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[1] Nowrey, Joseph E., "A Brief Synopsis of Mental Deficiency," American Journal of Mental Deficiency, Volume XLIX, Number 3, January, 1945, pp. 342-343.

the most part prisoners confined to the two institutions. Patients were chained and tied with ropes and as a result of such unjust treatment reacted with rage, indignation, shrieks and howls. Added to the above degradation was the practice of charging an admission fee to the general public who considered viewing their less fortunate peers as a form of amusement.

Early care of the mental retardates in the United States was similar to that found in Europe. Wolfensberger's description indicates the plight of these unfortunates in colonial days: "In early America, the Puritans looked with suspicion on any deviation from behavioral norms, and irregular conduct was often explained in terms of the supernatural, such as witchcraft. There is reason to believe that retardates were hanged and burned on this suspicion. Later in New England, records showed that lunatics, distracted persons, people who were non compos mentis, and those who had fits were all classed together, perhaps with vagabonds and paupers thrown in. Connecticut's first house of correction in 1722 was for rogues, vagabonds, the idle, beggars, fortune tellers, diviners, musicians, runaways, drunkards, prostitutes, pilferers, brawlers--and the mentally afflicted."[2]

Although philosophers and others had explanations of mental retardation from the middle ages onward, medicine was unconcerned about it. In fact, until the end of the eighteenth century, there were only rare references in medical literature. "It is easy to agree with Weygant, who wrote in the introduction of his classical monograph on

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[2]Wolfensberger, Wolf, Changing Patterns in Residential Services for the Mentally Retarded, Part IV, History and Development, Chapter 5, The Origin and Nature of our Institutional Models, p. 70. Robert B. Kugel and Wolf Wolfensberger, (Editors), U.S. Government Printing Office, Washington, D. C., 1969.

idiocy and imbecility: 'While the writers of antiquity gave vivid and correct descriptions to specific psychotic conditions (e.g., Hippocrates of epilepsy and Aretaeus of mania and melancholea) idiocy has rarely been mentioned until recently.' Any bibliographic quest for publications in the area of psychiatry, neurology, and psychology leads one invariably to Heinrich Laehr's complilation of the pertinent writings from 1459 to 1799. In this magnificent collection, which comprises two hugh volumnes and a separate index of authors and subjects, there is among the many thousands of recorded and sometimes annotated items, not one, however faint, allusion to mental deficiency, except for the evidence of sporadic interest in cretinism toward the end of the Middle Ages."[3] The study of mental deficiency as a specialized branch of medicine could not develop until investigators realized that mental defect required treatment dissimilar to that of mental illness. "Scholars knew quite early that madness and idiocy presented different clinical pictures, but both being classed as manifestations of an abnormal mind, were therefore subject to similar and often ineffectual forms of the empirical treatment of the day."[4]

Early educators were acutely aware that there were children who did not respond to the orthodox methods of teaching. The most frequently mentioned were the idiotic children. Another, less conspicuous class was the simpleton, (to be later called imbecile). For a long time no effort was made to teach these groups, until in 1798, Itard, a French Otologist, attempted to train Victor, the "Wild Boy of Aveyron."

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[3]Kanner, Leo, A History of the Care and Study of the Mentally Retarded. Springfield, Illinois: Charles C. Thomas, Publisher, 1964, pp. 7-8.

[4]Nowrey, op. cit., p. 343.

"He was entirely untrained in any way when captured, being not only idiot by deprivation, but also, according to Pinel, an idiot at birth. He attempted to train this boy by methods then in use in the training of deaf mutes, and while he was disappointed with the results of his experiment, he noted much that he considered significant."[5]

> The insane were divided into two groups: (1) violent and dangerous, and (2) the harmless and mild. The former were treated as criminals and the latter as paupers. Mental defectives were usually grouped with the latter class. The paupers, including the mildly insane and the mental defectives, were cared for by public funds in the following ways: (1) in their own homes, (2) in almshouses, and (3) by auction to the lowest bidder, (i.e., to a person who agreed to support the pauper at the lowest cost to the community in return for which the pauper worked for the successful bidder in order to earn his keep). Sometimes a single contractor would bid for the care of all the paupers, exploiting them for the work he could get out of them. This system of auctioning off the poor originated in the northeastern section of the country and was known popularly as 'the New England System.' The paupers were brought to the auction block. The bidders stood in front, calculating the potential working ability of the goods offered for sale. The insane and feeble-minded were the most eagerly sought after, as they were usually capable of a maximum of work with a minimum of remonstrance. The bidding proceeded downward and not upward, and to stimulate the bidding further a free drink of liquor was given to any person who lowered the bid of a previous bidder. Although some communities required a bond to be posted to insure 'decent' treatment of these public charges, this was often a mere formality.
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> Fortunately, public opinion became strong enough by 1835 to demand the discontinuance of this practice, and it gradually began to disappear from most parts of the country. As this practice became less prevalent, the custom of sending the aged and infirmed, the lunatic and the idiot to the poorhouse became the common one. With the establishment of these places the percentage of insane, idiots, and helpless persons gradually became larger until it required all the time of those inmates who could work to take care of those who could not. Conditions in the almshouses grew worse

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[5] Ibid., pp. 344-345.

> and worse, due to crowding and lack of appropriations, until Dorothea L. Dix began her crusade for state hospitals in 1841. The activity of this fearless pioneer for humane treatment of the insane did more to establish state hospitals for the psychotic, and indirectly, state schools for the mentally deficient, than the combined efforts of both the medical and legal professions. Nevertheless, the construction of state schools were spread over a long period of years, and the capacities of these institutions could never equal the number of applicants, and on this account for many years the jails and poorhouses continued to be used as places for the confinement of mental defectives and the mentally ill.[6]

Edouard O. Sequin was born January 20, 1812 and studied medicine and surgery under Itard, who encouraged him to devote himself to the investigation and treatment of Idiocy. In 1837, Sequin attempted to educate an idiotic boy. He worked with him steadily for eighteen months, at which time, his pupil was able to make better use of his senses, could remember and compare, speak, write and count. Sequin began to teach more children at the Hospice des Incurables and at the Bicetre. In 1843, a commission gave a detailed report of their examination of his work and stated: "Sequin has thus opened up a new career of beneficence. He has given to hygiene, to medicine, to ethics an example worthy of being followed. We, therefore, have the honor of suggesting that a note of thanks be written to Monsieur Sequin for the communication which he has addressed to this Council, and that he be encouraged in his charitable enterprise."[7] In 1844, a commission examined ten of his pupils, and declared that he had solved the problem of idiot education. Sequin, later referred to the commission reports as the cornerstones of all mentally retarded institutions.

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[6] Ibid., p. 347.

[7] Kanner, op. cit., pp. 35-36.

In 1846, Sequin published his classical textbook. In this widely read manuscript, he described his method of instructing idiots. "According to this method, education is the ensemble of the means of developing harmoniously and effectively the moral, intellectual and physical capacities, as functions, in man and mankind. To be physiological, education must at first follow the great natural law of action and repose, which is life itself. To adopt this law to the whole training, each function in its turn is called to activity and to rest; the activity of one favoring the repose of the other; the improvement of one reacting upon the improvement of all others; contrast being not only an instrument of relaxation, but of comprehension also. The general training embraces the muscular, imitative, nervous, and reflective functions, susceptible of being called into play at any moment."[8]

Sequin became famous and men of many nations flocked to Paris to view his work. Then came the 1848 revolution and being distrustful of the new government Sequin emigrated to the United States.

INSTITUTIONS IN THE UNITED STATES.--The American Asylum for the Deaf and Dumb, at Hartford, Connecticut, experimented with the idea of training idiots as early as 1818, but this attempt was soon abandoned and America's first successful schools date from 1848.

A probable stimulus to establishment of institutions for the mentally retarded in the United States were appeals such as that of Dr. Samuel B. Woodward, first president of the Association of Medical Superintendents of American Institutions for the Insane and the Superintendent of the Massachusetts State Lunatic Hospital who in his annual report of 1845 to his Board of Trustees exorted them to remove

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[8] Ibid., p. 37.

the undesired and troublesome idiots from the asylum. The plea of Dr. William S. Chipley of the Eastern Lunatic Asylum, at Lexington. Kentucky demonstrates the intensity with which the removal of idiots was sought: "There is one class of persons frequently committed to the Asylum, as provided by law, in whose behalf I esteem it a duty to appeal to the humanity and generosity of the Commonwealth. I allude to idiots. The attention of your board has been heretofore directed to the manifest evils resulting from the promiscuous mingling of those persons with the insane. As early as 1848 you said: 'We are sure that every one having any experience on this subject will testify, most strongly, against the evil effects of such unions, and the injurious consequences of such association to the lunatic.' And you state very correctly and circumstances under which these persons are generally sent to the Asylum: Whenever an idiot becomes so utterly diseased and helpless that no one will support him for the fifty dollars allowed by law, he is sent to the Asylum."[9] Similar appeals for the removal of idiots and also the epileptic from the Michigan Asylum for the insane were frequently recorded in the Annual Reports of the Board of Trustees from 1860-1890.

On April 11, 1846, the General Court of the Commonwealth of Massachusetts passed an Act requiring the appointment by the Governor of a Commission "to inquire into the condition of the Idiots of the Commonwealth, to ascertain their number, and whether anything can be done in their behalf." Dr. Samuel G. Howe was named Chairman of the Commission. Dr. Howe had spent his first six years after graduation from medical school as a surgeon in the war of the Greek Revolution.

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[9] _____, "Education of Idiots at the West," American Journal of Insanity, Volume XI, April, 1856, p. 317.

Upon return to the United States he collected $60,000.00 which he personally disbursed in a relief station he established in Aegina. Later he established a refugee colony for war exiles. In 1831, interested in establishing an asylum for the blind he returned to Europe to investigate its facilities in this field. Temporarily diverted from this task by a commission from Lafayette to carry funds across the Prussian frontier to the Polish revolutionists beyond, he was caught and imprisoned for awhile in Berlin. In July, 1832, he took a few blind children into his father's home. There was born the beginning of the future Perkins School for the Blind. He was the first to attempt the education of a blind deaf-mute and he began the first printing press for the blind in America. Howe was a supporter of Dorothea Dix and was responsible along with Horace Mann for the reformation of the Massachusetts educational system.[10]

On February 28, 1848 Howe's Commission presented the "Report to inquire into the condition of the idiots of the Commonwealth" to the Senate of the General Court of the Commonwealth of Massachusetts. In part it said:

> Massachusetts admits the right of all her citizens to a share in the blessings of education; she provides it liberally for all her more favoured children; if some be blind or deaf, she still continues to furnish them with special instruction at great cost; and will she longer neglect the poor idiot--the most wretched of all who are born to her--those who are usually abandoned by their fellows--who can never, of themselves, step up upon the platform of humanity, will she leave them to their dreadful fate, to a life of brutishness, without an effort on their behalf?
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> It is true, that the plea of ignorance can be made in excuse for the neglect and ill treatment which

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[10] Haskell, Robert H., M.D., "Mental Deficiency Over a Hundred Years," American Journal of Psychiatry, Volume CII, pp. 107-118.

> they have hitherto received; but this plea can avail us no longer. Other countries have shown us that idiots may be trained to habits of industry, cleanliness and self-respect; that the highest of them may be measurably restored to self-control, and that the very lowest of them may be raised up from the slough of animal polution in which they wallow; and can the men of other countries do more than we? Shall we, who can transmute granite and ice into gold and silver, and think it pleasant work--shall we shrink from the higher task of transforming brutish men back into human shape? Other countries are beginning to rescue their idiots from further deterioration, and even to elevate them; and shall our commonwealth continue to bury the humble talent of lowly children committed to her motherly care, and let it rot in the earth, or shall she do all that can be done, to render it back with usury to Him who lent it? There should be no doubt about the answer to these questions. The humanity and justice of the legislature will prompt them to take immediate measures for the formulation of a school or schools for the instruction and training of idiots.
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> The benefits to be derived from the establishment of a school for this class of persons, upon humane and scientific principles, would be very great. Not only would all the idiots, who should be received into it, be improved in their bodily and mental condition, but all the others in the state and the country would be indirectly benefited. The school, if conducted by persons of skill and ability, would be a model for others. Valuable information would be disseminated through the country; it would be demonstrated that no idiot need be confined or restrained by force; that the young can be trained to industry, order and self-respect; that they can be redeemed from odious and filthy habits, and that there is not one of any age, who may not be made more of a man, and less of a brute, by patience and kindness, directed by energy.[11]

The first permanent institutions of the mentally retarded in the United States were started in 1848. At Barre, Massachusetts, in the early summer, Dr. Hervey E. Wilbur, a young practicing physician received the first pupil, a seven year old son of a distinguished lawyer, into his home, stating: "This institution is designed for the

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[11] Haskell, op. cit., pp. 108-109.

management and education of all children who by reason of mental infirmity are not fit subjects for ordinary school instruction. It aims to nourish and encourage the growth of what may be mere germs of functions and faculties, to direct these functions and aptitudes in the natural channels of physical and mental labor, and to give to the subjects of it the greatest possible resemblance to children well endowed and properly educated."[12]

Mrs. Catherine W. Brown, wife of Dr. George Brown, who in September succeeded Dr. Wilbur, when he accepted appointment as superintendent of the soon to be opened New York State Asylum at Albany, New York briefly describes life in the newly established school as follows: "We were teachers, supervisors, and attendants by turn, with a single domestic in the kitchen. The children sat with us at table that we might seek to cultivate good habits of eating, or in the sitting room that we might direct their ways and continually prune their uncouth habits of body. Such intimate association gave us practical insight of the characteristics, needs and ways of reaching such darkened minds. When our helpless ones were safe in bed we sat down to read M. Sequin's Traitment Moral, Hygiene et Education Des Idiots."[13]

In October of 1848, Dr. Howe brought ten idiotic children together at the Perkins Institute and Massachusetts Asylum for the Blind. It was his expectation that these youths, "below the grade of simpleton, be trained up to cleanliness and decency; to prevent or root our vicious

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[12] Brown, George A., M.D., "President's Annual Address," Journal of Psycho-Asthenics, Volume III, Number 1, September, 1898, pp. 1-2.

[13] Brown, Catherine W., "Reminescences," Journal of Psycho-Asthenics, Volume III, Number 1, September, 1898, pp. 134-140.

habits, to moderate gluttonous appetites; and to lessen the strength of the animal nature, generally by calling into some activity and higher feelings and desires, and by substituting constant occupation for idleness."[14] The above mentioned improvements in behavior, according to Dr. Howe were to be obtained in training "all the senses and perceptive faculties by constant and varied exercises, to strengthen the power of attention; to teach, as much as possible, the rudiments of knowledge; to develop the muscular system; and to give some degree of dexterity in simple handicraft. Efforts will be made to call out their social affections, by awakening some feeling of regard for others, in return for kindness and love manifested towards them."[15]

In his second report to the Legislature, Dr. Howe was of the opinion that the hopes and expectations he had for his experimental school had been fulfilled. In describing the improvement of the pupils he related: "They have improved in health, strength, and activity of body. They are cleanly and decent in their habits. They dress themselves, and for the most part sit at table and feed themselves. They are gentle, docile, and obedient. They can be governed without a blow or unkind word. They begin to use speech, and take great delight in repeating the words of simple sentences, which they have mastered."[16]

The early success of the enterprise was attributed to Mr. J. B. Richards, who was the teacher, and his assistants who were

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[14] Howe, Samuel G., M.D., "On Training and Educating Idiots," Journal of Insanity, Volume VIII, Number 2, October, 1851, p. 100.

[15] Howe, op. cit., p. 100.

[16] Ibid., p. 103.

not further described. The general routine which was followed in obtaining the above mentioned success is vividly detailed:

> A plain but plentiful diet; abundance of sleep; cold bathing, followed by friction; walking and running in the open air; gymnastic exercises, for giving muscular activity and strength; amusements of various kinds:--such are the means relied upon for promoting and maintaining the bodily health of the pupils. An improvement of the physical condition and a nearer approach to a normal state of health, naturally begets greater freedom and precision in the action of the mental powers; just as repairing and cleansing the works of a watch causes greater precision in the motion of the hands.
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> Special care and attention has been given, however to bring out and to train the feeble mental faculties of the pupils, by simple exercises, adapted to the purpose.[17]

In the latter part of his report, Dr. Howe expressed his opinion of the more than two years experience of teaching mental retardates in the following manner:

> I consider this experiment, therefore, to have been entirely successful. It has demonstrated beyond question that, among those unfortunate human beings who are left to grovel in brutal idiocy, there are many who can be redeemed and elevated, and made to be comparatively intelligent, and happy and useful. Here stand the rescued ones, living proofs of the power of education. Let even the most sceptical examine them closely; their doubts will be removed. Let those who have disapproved the project as a vain and hopeless one, and those, also who have ridiculed it as a presumptuous one, (for there have been both, and in high places, too), let them come, and see whether they have not unwittingly been encouraging an abandonment of their fellow-beings, who might have been saved from a condition at which humanity shudders.[18]

It is worthy to note that Howe did not accept all intellectually impaired children because he excluded five of the initial entrants for the following reasons: "Three were found to be more deranged than

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[17] Ibid., p. 105.

[18] Ibid., p. 117.

idiotic. One proved to be hydrocephalic, and was discharged on that account and one was so feeble and unhealthy, and required such constant nursing as to be unfit for an experimental school.[19] In 1851, Dr. Wilbur wrote into the by-laws of the New York State Experimental Asylum more explicit limitations for admission eligibility. In his words, "Only idiotic children who were not of custodial character, epileptic, insane or greatly deformed and between the ages of seven and fourteen years would be admitted."[20]

Thus, with expectations of great success the initial institutions for the mentally retarded were launched. Allocated funds were small, pupil enrollment few but the missionary ardor of the founders great. By laboring long hours in the behalf of their charges there was little need for the assistance of ancillary personnel. Despite the small number of retardates enrolled in the early institutions, information of their success was widely disseminated into other states, to the extent that fifteen institutions existed forty years later.

The original optimism did not prevail for long. The expected outward flow of graduates from the original schools to permit the entrance of new pupils did not result. A build up of static population prompted Dr. Wilbur, in 1869, to comment: "There is necessary a separation of the two classes of idiots; viz., those who can be benefited by instruction and those who are unteachable."[21] He goes on to state: "The

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[19] Ibid., p. 104.

[20] Haskell, op. cit., p. 109.

[21] Wilbur, H. B., "Annual Report of New York State Asylum," Journal of Insanity, Volume XXVIII, Number 4, 1870, p. 368.

degree and extent for the education of the idiot may not have been as great as first predicted."[22]

On June 6, 1876 the first meeting of the Association of Medical Officers of American Institutions for Idiots and Feebleminded Persons was held at the Pennsylvania Training School. The Philadelphia Medical Times commented on the newly formed organization as follows:

> An interesting meeting of the Superintendents of American Institutions and Asylums for the Feebleminded and Idiotic was held last week (June 6, 7 and 8) at the Pennsylvania Institution, near Media, resulting in a full discussion of the objects and conditions of this comparatively new work, and the organization of a National Association to advance its interests. Seven gentlemen, from the eight institutions already founded in successful operation, were present, from States as follows: Massachusetts, New York, Connecticut, Pennsylvania, Ohio, and Illinois. The position assumed from the experience of those present is, that legislation in behalf of this afflicted class should be no longer experimental, and that public money whenever expended should be directed at once to suitable buildings and premises expressly for the purpose intended, it having been proven in Germany, England, and America, That a fair percentage of admissions (from 10 to 20 per cent) can be rendered self-supporting, that few cases are not capable of some amelioration, and that the habits of all can be improved so as to render the patients happier themselves, less afflictive to others, and more cheaply and humanely cared for in asylums than scattered in the community.
>
> Many questions of importance lie over for consideration at the next meeting, to be held in Columbus, Ohio, June 5, 1877; such as Idiocy and Imbecility, how far preventable or capable of diminution? To what extent should the education and training be directed toward industrial development? Whether adult asylums can be wisely managed as establishments for manufacturing or agricultural industry? The best modes of treating and providing for those who only need supervision, shelter, and kind care?
>
> It is perhaps too early to expect reliable statistics of a social and psychologic character from

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[22]Wilbur, op. cit., p. 368.

> gentlemen who have been of necessity immersed in the details of building for and training this hither to hopeless class. Excepting annual reports, and the interesting and valuable work on Idiocy by Dr. E. Sequin, no contributions have been made to the literature of the subject in this country. It is to be hoped that, with organization and increasing opportunities for observations something will yet come from this new and broad field of scientific research.[23]

It is in this period of the formation of the first organization of persons associated with retarded institutions that important changes began to take place. Kuhlman states: "That there is plenty of evidence that radical departures from the ideas of 1850 about mental deficiency are not far distant."[24]

In 1875, the number of state schools was eight. Enrollments that began with twenty or less pupils had increased to several hundred in the case of a few schools. The public had accepted the idea of having schools for mental defectives. Waiting lists of children who could not enter for lack of space grew each year. It could no longer be said that mental defectives could be cured by special training. The entrance of untrainable cases happened against the objections of superintendents and state laws that prohibited such admissions. State schools became asylums for incurables.

> Various reports showed that from one half to two thirds of the admissions were regarded as untrainable. Moreover, many of those who had been under training for the number of years that were allowed by the laws remained indefinitely and in opposition to retention laws, because it was recognized that the purpose for which they had been admitted had not been realized.

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[23] Nowrey, op. cit., p. 349.

[24] Kuhlman, F., "One Hundred Years of Special Care and Training," American Journal of Mental Deficiency, Volume XLV, Number 1, September, 1940, p. 9.

They had not improved to a point where it was felt that they could be returned to the community, capable of meeting the requirements of normal children. Undoubtedly there had been considerable difficulty in classifying children as definitely trainable or untrainable, because of the lack of an adequate method. But even if there had been such a method, any effort to apply it would probably have been ineffective. A public that had been told that mental defectives could be restored to normal by this training would not likely have tolerated a distinction between individual cases that held out this hope for some and denied it to others. . . .

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In recognition of these facts, the State Schools had begun to make important re-adjustments. One of these was the training of pupils for permanent retention in the School. This applied to a middle group between the untrainable and those who might be returned to the community. It was a natural step. There were many tasks in which the school needed help, in the kitchen, dining rooms, dormitory, and on the farm. If pupils could be taught to give satisfactory service in these tasks it would give valuable practical training to the pupils and save money for the School at the same time. In addition to this, it provided a life-time home and useful employment for the pupil. . . .

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Along with this adjustment came another. The 'physiological' training of Sequin to develop intelligence was being superceded largely by industrial training to supply skills in various occupations. This applied to the brightest pupils in qualifying them for return to the community. Skill became a substitute for intelligence although this fact was not discussed and apparently not recognized at the time. Shops for industrial training were added to the School. In some instances they supplemented to quite an extent the school occupations themselves, such as found in the bakery, laundry, dormitory and farm. . . .

. . . . . .

Summing up this period, we may say that it marks the turning point for changes in several directions. We are leaving behind the school of yesterday that knew only school pupils, and are coming to the institution of tomorrow that will know also custodial inmates. The big school house of the past is enlarging into groups of buildings that include custodial wards, and shops, and enlarged acreage with farms and dairy herds. We are still thinking only of helping the mentally defective and not yet of protecting society.

> We are not yet aware of their number, of the economic losses for which they are responsible, of the delinquencies and crimes they commit, and of the general havoc they create in our social order. By degrees we shall hear of all these things. Talk of permanent retention in the State Institutions for most is already in the air, and compulsory commitment will be heard about soon. An important change in the public attitude is to take place during the next twenty-five years. . . .[25]

Something else was happening that would have great impact on the future status of the mental retardate. An inspector of jails in New York, R. L. Dugdale, reported to the American Prison Association in 1875 of his study of crime, pauperism and disease in five generations of the Juke family, and related the conditions to feeblemindedness and other adverse conditions. "Dugdale did not develop the theme of heredity as the factor producing the continuity of such social inadequacy through this family. Indeed his stress was on the etiologic importance of the environment. Under the influence, however, of this study were initiated the first planned custodial provisions in this field, the creation of the New York Asylum for feebleminded women of child bearing age."[26]

According to Wolfensberger by 1875:

> The Institution is no longer to be a school, but a shelter, an asylum of happiness, a garden of Eden for the innocent. What doubt there may have remained was largely dispelled by the close of the century: Slowly but surely the conviction has become general, especially among the trustees and officers of institutions, that admission as a pupil of the training school should be but the first step to permanent care; that, with a few exceptions, so few that they may be disregarded in establishing a policy, all the pupils of the school, from the lowest

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[25] Ibid., pp. 9-11

[26] Haskins, op. cit., p. 112.

> to the highest grade, ought to be permanently retained in the safe, kindly, maternal care of the state. The above conviction is held by all who have expressed themselves publicly within the last few years in this country, excepting a few persons whose pecuniary interests seem in conflict with such a theory. It has been acted upon by the legislature of many states, whose laws have been changed by removing from the institution code the age limit of retention, and in some cases of acceptance. A belief in the necessity of permanent care for all this defective class is professed by the superintendent of every state school for the feebleminded in the United States today.[27]

The residential institution for the retarded of that day emphasized benevolent shelter. The retardate was to be placed in an institution in order to protect him from the persecution and ridicule of society. Special protective care required that provisions be made for growth in population and meeting the many needs of the adult resident.

ESTABLISHMENT OF THE MICHIGAN HOME FOR THE FEEBLEMINDED AND EPILEPTIC.--Minutes of the Board of Trustees of the Michigan Asylum for the Insane at Kalamazoo during the 1860's and the minutes of the Joint Meetings of the Michigan Boards of Asylum Trustees from 1877 onward repeatedly expressed the need for the establishment of an institution to care for the idiots and epileptics. Finally in 1893 Representative W. B. Baum of Saginaw introduced and the Michigan State Legislature passed Public Act No. 209, "An Act to establish a home and training school for the feebleminded and epileptic, and making an appropriation for the same."[28]

This Public Act stated: "There shall be established in this State an institution for the custody, care, education, proper treatment

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[27]Wolfensberger, op. cit., p. 96.

[28]Michigan Public Acts, 1903, p. 412.

and discipline of the feebleminded and epileptic persons, under the name and style of the Michigan Home for the Feebleminded and Epileptic."[29]

At the time of the signing of this Act on June 2, 1893, Governor John T. Rich appointed three commissioners to select a suitable site and erect and furnish buildings for the Home. Ex-Governor Cyrus G. Luce. former State Senator John C. Sharp, and newspaper editor Loren A. Sherman were Governor Rich's appointees. From the State treasury $50,000.00 was appropriated for the purpose of putting into effect the provisions of the Act which further stated that the general supervision and government of the institution should be vested in a board of control of three members to be appointed by the Governor.

Section Seventeen of said Act stated: "The said board of control shall have the sole and exclusive control and management of the said institution and its affairs. It shall establish a system of government and make all necessary rules and regulations for enforcing discipline, for imparting instruction, for preserving health, and for the proper physical, intellectual, and moral training of the inmates of said home."[30]

As to who might be admitted to the home Section Twenty of the Act stated:

> All feebleminded and epileptic persons between the ages of six and twenty-one years who are legal residents of the State of Michigan may be admitted to said home without charge for tuition, boarding, lodging, washing, medicine or medical attendance. In the selection of inmates preference shall be given to

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[29] Ibid., p. 412.

[30] Ibid., p. 415.

> indigent or pauper orphans, and when this class is provided for such others may be admitted for whom applications may be made, and as accommodations may be provided for by sufficient buildings. And when these classes are provided for other feebleminded and epileptic persons who are entitled to admission may be received at such institutions.[31]

Section Twenty-one of the Act 209 gives expression to the object of the institution:

> The object of said institution shall be to provide by all proper and feasible means, the intellectual, moral and physical training of that unfortunate portion of the community who have been born or by disease have become imbecile or feebleminded or epileptic, and by a judicious and well-adapted course of training and management to ameliorate their condition and to develop as much as possible their intellectual facilities, to reclaim them from their unhappy condition and fit them as far as possible for future usefulness in society.[32]

The appointment of duties of personnel are contained in Sections Twenty-three and Twenty-four:

> Sec. 23. The board of trustees shall appoint a medical superintendent, who shall be a well educated physician, experienced in the treatment of the feebleminded and epileptic. They shall also appoint upon the nomination of the medical superintendent a steward.
>
> Sec. 24. The superintendent shall daily ascertain the condition of all the patients and prescribe their treatment, subject to the rules of the board; he shall appoint, with the approval of the board of control, such and as many assistants and attendants as the board may think necessary and proper for the economical and efficient performance of the business of the home, and to prescribe their several duties and places, and with the approval of the board their compensation, and may discharge any of them at his sole descretion, but in every case of discharge he shall forthwith record the same with the reasons

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[31] Ibid., p. 416.

[32] Ibid., p. 416.

> under an appropriate head of one of the books of the home.[33]

Sections Twenty-six, Twenty-seven, and Twenty-eight set down the manner in which admissions were to be made to the Home:

> Sec. 26. The superintendents of the poor in each of the counties of the State in which they are or shall be persons of this class eligible to admission to this home by the provisions of this act, who have no contagious disease, and who are, or shall become chargeable to said county, or to any township therein, shall cause all, or any such persons to be taken to the home for the feebleminded and epileptic and to be taken into the custody and care of said home, in accordance with the rules and regulations of said home. No person, however, shall be admitted to said home, until a certificate of admission has been issued for the admission of said person by some officer of said home duly authorized by the board of trustees to issue such certificate.
>
> Sec. 27. The superintendents of the poor shall cause any and all such persons to be taken to the Home for the Feebleminded and Epileptic at the expense of the county, and to be taken into (the) custody and care of the school in accordance with the rules and regulations of said home.
>
> Sec. 28. The superintendent of the poor in every case before taking or sending any person to said home as provided in Sections Twenty-five and Twenty-six of this act, shall see that such person is in a state of perfect bodily cleanliness, and comfortably and decently clothed.[34]

Indications are that the commission appointed by Governor Rich set to work at once to learn about institutions in other states and to give consideration to the area in which the Michigan Home for the Feebleminded and Epileptic should be erected.

Information pertaining to the selection of Lapeer as the site of the new institution follows: ". . . The Governor at this time was the

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[33] Ibid., p. 417.

[34] Ibid., p. 417.

Honorable John T. Rich of Lapeer who used his influence to make Lapeer the location of the institution. . . . The City of Lapeer donated the one hundred sixty acres upon which the buildings are located."[35] January 19, 1894 Lapeer newspaper item told of the ire of the citizens of Greenville who were seeking to have the new institution erected there. It was stated: "Lapeer is nothing but a swamp hole and no foundation can be found for the buildings."[36] The newspaper indicated that numberous areas of the State sought to have the institution erected in their geographic area.

A newspaper interview with Representative W. B. Baum of Saginaw, the sponsor of Public Act 209 of 1893, on June 8, 1894, the day of the corn stone laying for the new Home told of legislative reactions while Act 209 was being considered: Typical questions were: "What can you do with them after you've got your school? What can you do with a fool anyhow? Representative Baum answered: "We can do as well with them in Michigan as they do in Columbus, Ohio. Then I showed them the report of that institution proving that 50 per cent could be so developed that they could learn geography and that 60 per cent could thus learn some light handicraft."[37]

On March 23, 1894 Loren A. Sherman, secretary of the Board of Building Commissioners visited the site selected at Lapeer along with Civil Engineer Paldi to lay out plans of operation. In a newspaper interview, Mr. Sherman said: "It is estimated that there are now 3,000 people who are subjects for the school, but it will scarcely be possible

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[35]Bently, Roy. "How We Grew," Employees' Reporter, Lapeer State Home and Training School, Volume 5, Number 6, June 14, 1945, p. 1.

[36]Lapeer Clarion, Volume 39, Number 3, p. 1.

[37]Lapeer Clarion, Volume 39, Number 23, p. 1.

for the Commission; with the sum at their disposal, to provide for more than a hundred or two at present. The design is to put in the sewers, erect the boiler house and somewhat lay out the grounds, besides building two, so-called cottages. These 'cottages' are to be three story bricks, accommodate seventy-five people each; one of these is for males, the other for females. The 'cottages' are to cost $14,000.00 each, and the whole amount expended in building this year will be about $42,000.00 leaving $3,000.00 for sewers and $5,000.00 for running expenses."[38]

The June 29, 1894 headline of a Lapeer paper read: "CORNER STONE OF MICHIGAN'S NEW INSTITUTION LAID AMID POMP AND SPLENDOR." Ex-Governor Cyrus G. Luce of Coldwater delivered the principal address of the day. The corner stone was laid with Masonic ceremonies and an estimated crowd of 25,000 was present. Portions of Governor Luce's address follows:

> The leading characteristic of the 19th century is the onward march of humanity. . . . This quality of humanity, thus developing year by year through Christian education, demands more and more care for the unfortunate. Thirty-five years ago there was no place in Michigan where the insane could be provided for or taken care of. These afflicted creatures were found in the country and hamlet where they frightened children and were a scare and a horror to the women who encountered them. During the year 1859, however, an asylum for the unfortunate insane was established at Kalamazoo. . . . Michigan has provided for her deaf and dumb at Flint. Dependent children are cared for at Coldwater. It has been asserted that after the insane should follow the feebleminded in the claim for care from the State. My opinion is that the State should take care of its insane first always, second its blind, third its feebleminded. . . . The law under which this Home is to be erected wisely provides not only for the care and custody of the epileptic and feebleminded but does not make the mistake of perpetual custody of those who under its training, become improved,

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[38] Lapeer Clarion, Volume 39, Number 12, p. 1.

> neither does it force into the world again those who having entered are not developed to such a condition that they can care for themselves. . . . And now the good thing is here, and all of this unfortunate class between the ages of six and twenty-one are eligible. It is our duty to educate and cultivate, in so far as possible, and Michigan has done that duty well for every class except her feebleminded, which alone has stood out in the cold.
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> When we considered the place for establishing, we visited institutions of the same kind in other states, we went to Columbus, we went out into Indiana and everywhere they said. The president of one of these Homes down in Pennsylvania, speaking of what can be accomplished, stated that in forty years of operation thirty-five per cent have been so improved as to go out and become self supporting.
>
> All, to be good citizens must work. These weak minded must work and they take to the soil more naturally than anything else. In all you ever have here I'll guarantee there won't be more than one or two inventors. There won't be any lawyers. There won't be any preachers nor aspirants in other educated lines. But they make good tillers of the soil and transform it into an Eden, with no Eve in it. It is no use to put these unfortunates in schools but this Home will give them kindergarten work in which they are capable of showing some interest when they will not in anything else. . . . This is the twentieth institution of the kind in our country. The inmates of these schools are ignorant of the laws of their own being and incapable of self control. They must be kept from and cured of diseases. They need special care and custody for reasons of which I cannot here speak. The girls, perhaps more particularly but the boys as well in many cases, have not the power to resist impulses that pertains to the sexes. Mr. Baum in his bill has provided that they should be improved, cared for and not turned out while in this condition. . . . Let me assure you that this Home will be of great benefit to your city; in fact, it is already.[39]

Construction continued throughout the winter and early in 1895 it was announced that Dr. W. A. Polglase was appointed superintendent starting on March 1st. A short item in the local newspaper stated that he was a graduate of the Chicago School of Medicine, had practiced in

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[39]Lapeer Clarion, Volume 39, Number 3, p. 1.

Detroit for seventeen years, was a specialist in nervous diseases and was on the staff of Grace Hospital.[40]

In early April of 1895 the Board of Building Commissioners for the Michigan Home for the Feebleminded and Epileptic met in Detroit. In a letter to Governor Rich, inviting him to attend, the stated purpose of the meeting was "to decide upon the employees and the salaries to be paid them and the rules and regulations for the government of the institution. As you are much better posted as to the management of other institutions than any other member of the commission, it would seem to me that it would be very desirable that you should be with us at that time. Our subsequent business will be to decide upon furniture, and other like details, which would not require your attention."[41]

Other than another newspaper article stating that there were almost a 1000 applicants for positions at the Michigan Home for the Feebleminded and Epileptic nothing further is recorded about the new institution.[42]

"The first patients were admitted in August, 1895. The first boy was Lawrence Ward (died May, 1912) and the first girl, Ethel Annie Carter (now living in Cottage 30). By the spring of 1896 more than 200 patients were enrolled with about 16 employees."[43]

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[40]Lapeer County Democrat, Volume 55, Number 24, February 27, 1895, p. 1.

[41]Letter from L. A. Sherman, President, Board of Building Commissioners, Michigan Home for the Feebleminded and Epileptic, April 1, 1895.

[42]Lapeer County Democrat, Volume 55, Number 38, June 5, 1895, p. 1.

[43]Bentley, Roy, op. cit., p. 1.

CHAPTER III

PERIOD OF INDEPENDENT MANAGEMENT OF INSTITUTIONS IN MICHIGAN

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PERIOD OF INDEPENDENT MANAGEMENT OF INSTITUTIONS IN MICHIGAN (1895-1923)

The Michigan Home for the Feebleminded and Epileptic began and greatly expanded during the period of time when there was "an ever increasing interest in the problems presented by the feebleminded class. There has been a growing appreciation of the fact that feeblemindedness entered in and complicated a great many problems, especially those connected with dependency, crime and sexual immorality."[1] In order to determine the extent of the relationship of the problem to juvenile deliquency and dependency in the State of Michigan, a commission undertook a study of the populations of the Lansing Industrial School for Boys, the Adrian Industrial Home for Girls and all of the County Infirmaries in the state.

Prior to reporting result of the study the Commission felt it necessary to first define and discuss the general nature of feeblemindedness and the problems it presented. The report stated: "Feeblemindedness is defined by Tredgold as 'a state of mental defect, from birth, or from an early age, due to incomplete cerebral development, in consequence of which the person affected is unable to perform his

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[1] _____, Report of the Commission to Investigate the Extent of Feeblemindedness, Epilepsy and Insanity and Other Conditions of Mental Defectiveness in Michigan, Lansing, Michigan: Wynkook Hollenbeck Crawford Co., State Printers, 1915, p. 42.

duties as a member of society in the position of life to which he is born.' There are in common acceptation in this country, three terms used to express differing degrees of feeblemindedness: idiocy, imbecility and the moron group."[2] The report continues, stating that the idiots and lower grades of imbeciles were so defective that permanent care was necessary. Attention was focused on "the high grade imbeciles and the morons, who, though capable of contributing either partly or in whole to their own support, yet are the types which menace society with the increase of their kind."[3]

In regards to the etiology of feeblemindedness the Commission recognized that environmental conditions existing during the pre-natal period and in the early years of life as well as accidents were contributing factors but the major emphasis was that "Feeblemindedness more often is the results of a morbid heredity than of environmental causes. The degree to which inheritance dominates environmental influences as a cause of feeblemindedness is variously stated. Homer, Goddard, Davenport, and Tredgold agree that in at least 80 per cent of the cases of feeblemindedness heredity is the dominant cause."[4] Mention is made that the Mendelian law is in the main applicable to the inheritance of feeblemindedness and "since feeblemindedness is so largely the result of hereditary factors, procreation by feebleminded individuals should be prevented."[5]

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[2] Ibid., p. 42.

[3] Ibid., p. 42.

[4] Ibid., p. 43.

[5] Ibid., p. 43.

In order to learn of the problem feeblemindedness presented in Michigan the Commission decided to learn of its extent, the means being used to control it and the adequacy of such means. A June 1914 report found 1,141 individuals of defective mentality in the Michigan Home and Training School of which three hundred and twenty-four were also epileptic. The waiting list at the Lapeer institution had one hundred and sixty-five names, thirty-four of whom were epileptic. Twenty-four other epileptics were at the recently built Michigan Farm Colony for Epileptics at Caro.

In the State Hospitals for the Insane there were three hundred and fifty-three feebleminded and four hundred and eight epileptics. The Commissions' investigations found seven hundred and ten feebleminded and one hundred and fourteen epileptics in the County Infirmaries. At the Adrian Industrial Home for Girls there were one hundred and thirty-one feebleminded girls and the Lansing Industrial School had one hundred and seventy-one feebleminded boys. It was concluded that the extent of feeblemindedness was indeterminable in the communities at large.

The Commissions' report then focused on means being used to control feeblemindedness:

> Michigan has realized the fact that feeblemindedness is transmissible from generation to generation and consequently has adopted measures to prevent procreation. It has laws prohibiting the marriage of a feebleminded or an epileptic individual and inflicts heavy penalties upon anyone party to, or aiding in such a marriage. . . . . However, even were there the strictest enforcement of these laws, yet the illicit propagation of the feebleminded could not be prevented. . . . . Thirty per cent of the unmarried feebleminded women in the County Infirmaries

> have children. If restrictions against marriage were enforced, it would merely mean that these illegal unions would be increased. . . .
> . . . . . .
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> Michigan also recently enacted a law authorizing the sterilization of its insane and mentally defective. The law, however is inadequate from two standpoints. It limits the application of this means of preventing the propagation of the feebleminded class to those who are in institutions and therefore least likely to reproduce. Moreover, very little advantage has been taken of the right given by this act to prevent procreation. . . . There are also a considerable number of people who feel that the act of sterilization while preventing procreation, is a menace to society in that, by removing the restriction of sexual intercourse caused by fear of the possibility of consequent offspring it would tend to increase promiscuity and spread disease. . . .
> . . . . . .
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> Michigan has also attempted to segregate the feebleminded members of the state. At the present time, however, its institution for the special care of this class is crowded to the limit and has a long waiting list. There are about a fourth of the boys and about a third of the girls in the juvenile reformatories who are feebleminded and in a very few years will be turned out into the community at large. There are about one fourth of the inmates of the County Infirmaries of the state who are either feebleminded or epileptic and who are neither adequately nor permanently segregated.
>
> Since our marriage laws are not enforced, and since, if they were enforced, the propagation of the unfit would not be prevented, and since prevention by the means of sterilization has not been taken advantage of, the one method that stands out clearly as the most effective means of preventing the increase of our feebleminded class is increasing the extent of the segregation of its members and an especial effort should be made to permanently segregate the feebleminded women of child-bearing age.[6]

During a meeting of the American Association for the Study of the Feebleminded held at Lapeer, Michigan in June, 1913 Governor Ferris of

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[6] Ibid., pp. 44-46.

Michigan addressed the group in regards to solving the problems suggested by the feebleminded. He stated that progress would be handicapped until the time we cared more about human beings than we did for livestock. He expressed hope for the enactment of more stringent marriage laws, better control of immigration and the need to provide for the better rearing of healthy, promising boys and girls. He favored drastic measures being taken to segregrate defectives and bringing about the sterilization of sexual perverts.[7]

In 1920, Dr. H. A. Hayes, Superintendent of the Michigan Home and Training School added further to the knowledge of prevailing thoughts and attitudes of the era regarding the feebleminded. Regarding the first mass psychological testing of draftees with the Army Alpha and Beta he stated that "the results obtained by examining the draft furnished the lesson that would have taken fifty years to teach, and then we would not have had it in concrete form. Segregation is good as far as it goes but can we segregate this large per cent of society?"[8] Next consideration was given to the recently enacted Dry Law with expression of the hope that although it could not be expected that the birth rate of unfortunates would be lowered it would bring about better home conditions, "a greater co-operation on the part of parents, a greater interest because of the fact that the financial leakage caused by the opening saloon having been stopped"[9] and enable the family to better care for itself. The effort to wipe out veneral disease was

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[7]Ferris, Hon Woodbridge N., "Governor's Address," Journal of Psycho-Asthenics, Volume XVIII, Number 3, December, 1913, pp. 67-72.

[8]Hayes, H. A., "Address of the Vice-President," The Journal of Psycho-Asthenics, Volume XXV, Number 1, September, 1920, pp. 14-20.

[9]Ibid., p. 15.

cited as another positive step toward lowering the incidence of feeble-mindedness in the next generation.

Part of Dr. Hayes' address focused on the Colony System that had its beginning during this period. In his discussion of the subject he first opined that in the past the Home and Training School staff were content to house the feebleminded, educate them to the limit of their ability and train them to be helpful about the institution. When this was accomplished it was believed the inmates were happy because they were living in an environment fitted to their needs. He stated that the Colony System of New York State had shown that the above was not necessarily true and as a result Michigan institutions were trying out the Colony System and finding that it worked.

The System being tried was described as follows:

> After a period of institutional training certain girls are well fitted to go out from the institution into homes as domestics and find great enjoyment in so doing. It is a more normal life for them; they feel that they are in a large measure free, and the love of freedom is as strong in the higher grade girls as in ourselves. She is doing the things other people are doing and she is earning money. This is no small goal in most of our lives. Moreover she is making good morally in this experiment. She is proving her right to this larger degree of living. All of this is done under supervision.
>
> The same is true for the boys. They are happy holding down a job, be it even so small, outside the institution.
>
> These children may have their own colony building to which they return as to their home, or a rooming house; or they may live with families who will be responsible for their care.
>
> There is also another sort of Colonization which I believe to be a good thing in many ways, though, of course, it is not without some drawbacks.
>
> Under this plan, the huge and centralized institution of the past would be at an end. There would rather be a central or parent institution, where

> patients would be received and given a course of training, but a goodly proportion of the children would be living in small colonies scattered here and there about the state. Colonies of boys in a good agriculture district would operate separate farms for the good of the institution as a whole, and scattered units of girls would also live under the supervision of reliable matrons, and functions for the good of the whole.[10]

INSTITUTIONAL DESCRIPTION--The first biennial report of the Michigan Home for the Feebleminded and Epileptic began by stating: "We have endeavored in the management of the institution, thus far, to restrict current expenses to the lowest possible limit. We believe there has been no waste and that the exceedingly onerous duties of officers, teachers, attendants and other employees are performed at the lowest possible rate of compensation that can reasonably be offered."[11] Further stated objectives included making the Home self-supporting, or nearly so, so far as the care of adult custodials were concerned although it was conceded that children and low-grade feebleminded persons of adult age would have to be a burden to the state. Economy of operation was a primary concern of institutions of the era. Much consideration was given to the least expensive way to purchase coal, basic foods and other necessities for operation.

By June of 1899 the census was two hundred sixty-seven inmates who ranged in age from six to fifty-nine years. All grades of feeblemindedness were represented. It had been found necessary to place low-grade, uninstructable children who were also very destructive in

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[10] Ibid., pp. 18-19

[11] _____, Report of the Board of Control of the Michigan Home for the Feebleminded and Epileptic at Lapeer, 1896-1918, Lansing, Michigan: Robert Smith Printing Co., State Printers and Binders, 1906, p. 3.

a separate building because they were a detriment to the progress of the others.

Dr. Polglase indicated that "the life in the institution was made to resemble, as nearly as possible, home life with its duties, responsibilities and privileges and its little joys and pleasures."[12] Living areas constituting day room, sleeping dormitories and bathing-toilet facilities, as well as a sleeping room for the attendant, held twenty-five inmates. The attendant "watched every habit of life, regulated, directed and helped them to conform to the best type of physical, mental and moral perfection possible with a defect; the purpose being to promote usefulness and contentment."[13] Every child had their own toys and were encouraged to use them. The Superintendent went on to say: "every boy and girl of suitable age has some regular daily work assigned to them. This duty is very simple and could possibly be done by someone else, but it is a lesson in independence and happiness, for the busy child is generally a good child."[14]

Discipline was enforced without corporal punishment, by cutting off some pleasure or other similar means adapted to the misconduct. Love of praise was a factor used to encourage good conduct.

The initial report of the Lapeer institution went on to state that: "School children are drilled daily in marching, singing and calisthenics which alternates purely mental processes. Sewing, crocheting, knitting and fancy work are also taught in school and

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[12] Ibid., p. 5.

[13] Ibid., p. 7.

[14] Ibid., p. 8.

Sloyd work has recently been added (a system of manual training originating in Sweden, using wood carving as a means of training in use of tools). Music is used as much as possible, as it is a factor producing harmony of action and correlating discordant mental and physical irregularities, besides, we have already discovered enough musical talent, when cultivated to form the nucleus of a band."[15] In addition to the above, the five teachers who were hired in the first two months after opening placed great stress upon sense training and academics.

Initially it was thought that the inmates would not be able to do any work. It was believed they needed the same care as mental patients. Employees were hired to totally care for resident population and do all the work such as cooking, cleaning and making beds. Gradually, however, a few bright inmates were allowed to assist with the work.[16]

From the onset epileptics presented a problem as indicated in the institution's early reports which described them as the most troublesome and annoying cases who were always liable to injury or disturbing spells and even under the most watchful care were prone to damage either themselves or others. During the year 1916 the Michigan Home for the Feebleminded and Epileptic had one hundred and forty deaths. Twenty-eight were due to uncontrolled Epileptic Seizures and sixty-four to Tuberculosis. That year Typhoid Fever accounted for three others. Another medical problem of the early institution was Small Pox, an outbreak of which required strict quarantine in 1910.

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[15] Ibid., p. 11.

[16] Bishop, E. Beryl, "Worker Placement", Lapeer State Home and Training School Employees Reporter, Volume 5, Number 6, June 14, 1945, p. 8.

A summer school for public school teachers was started in 1912 under the guidance of Charles S. Berry, Ph.D., Assistant Professor of Education at the University of Michigan. In 1915, Dr. McCord of Parke Davis Company was permitted to do research which later developed into the production of Dilantin, an anti-convulsive medication.[17] Attendants salaries were $18.00 per month. The Michigan Home and Training School (name changed by legislative action in 1917) grew rapidly and in 1919 its census was 1543 with three hundred and five individuals on the waiting list. At that time it had added to the original staff a Psychologist, Registered Nurses, an Eugenics Worker and a Bandmaster. The school had eleven teachers and one hundred pupils. The average mental age of its population was four and nine-tenth years.

The second general rule of the Home's Rules and Regulations (APPENDIX A) best reflects the conditions under which employees worked during early institutional days. It stated that the entire time of the employees were contracted by the Home and they were not to leave the premises, or their assigned duties without permission of proper authority. Other rules of interest and indicative of the ear were the requirements that all personnel be in at 10:30 P.M. and the restriction of employee's visitors, as much as possible to Wednesdays from two to four P.M. Attire was also prescribed as indicated by the following: "I was rather pleased with the costume of the attendants. Being summer time, all male attendants were dressed in white and the women

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[17] Michigan Home for Feebleminded and Epileptic Diaries, 1908-1918.

in striped seersucker nurse-costume; supervisors and department-heads, on the girls' side, being in white."[18]

In order to better understand the scope of the worked performed the following is utilized: "While nurses and attendants are required as a rule to spend only eight hours per day in the care of patients yet their time still belongs to the state and they are to be accounted for every hour of the day or night by the general supervisor or superintendent of nurses. They are required to hold themselves in readiness for extra assignments, for emergencies such as the pursuit of escapes or for relief in cases of sudden illness, for practicing the fire drills, etc. There are other customary duties for them to attend to when not engaged upon the wards such as ushering visitors, caring for their own rooms, attending upon lectures, demonstrations, recitations, etc. in connection with the training school."[19]

The early institutional days were not without difficulties and one great concern was the "hospital tramps."[20] These were men and women, many times of questionable character who moved from one institution to another, staying a short time at each. They were readily hired because it was difficult to get employees for the attendant

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[18]Johnson, Alexander, "Notes on Institutions Visited--The Michigan School for Feebleminded," The Training School Bulletin, Volume 11, February 1915, p. 191.

[19]Noble, A. I., "Report of Michigan Asylum," Proceedings of the Meeting of the Joint Board of Trustees of the State Hospitals of Michigan, Lansing, Michigan: Wynkoop Hollenbeck Crawford Co., State Printers, 1913, p. 20.

[20]Christian, E. A., "Concerning Programmes for Joint Board Meetings," Proceedings of the First Semi-Annual Meeting of the Year 1903 of the Joint Board of Trustees of the Michigan Asylums, Lansing, Michigan: Robert Smith Printing Co., State Printers, 1903, p. 21.

positions. For example, it is recorded that during the year May 1908 to April 1909 thirty-nine women and twelve men left the employment at the Lapeer institution. The total number of attendant positions at the time was sixty-six. Some resigned but others were discharged because of drinking, striking an inmate with hair clippers, cruelty to an inmate and insubordination.[21]

The October 15, 1906 issue of the State Republican contained an item headlined: "Supt. Polglase to Leave Michigan Home for Feeble-minded." The sub headline went on to state: "Action the Outcome of Charges of Laxness in Management." The brief story said "No reason was given but it is understood the Board of Control took the initiative toward a change in the management. Recently the lax administration of the home was aired, and it was claimed the closest attention was not given its affairs."[22]

Correspondence to Governor Fred M. Warner shed further light on Dr. Polglase's resignation: "At a meeting yesterday, Dr. Polglase informed us of his decision to resign. . . . . After the developments in connection with the management, which were brought out, the board was a unit as to the desirability of a change, so this decision of the doctor's was most welcome. . . . . It was agreed that the matter of announcing the resignation would be left with the doctor, as it is desired to do anything within reason to make his future as easy as possible."[23]

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[21]Michigan Home for Feebleminded and Epileptic Diaries, 1909-1919.

[22]The Lansing State Republican, Volume 39, Number 88, October 15, 1906, p. 3.

[23]Letter from J. R. Johnson, Treasurer, Board of Control, Michigan Home for the Feebleminded and Epileptic, October 12, 1906.

Institutional notes indicated that an inquisition was held on September 20, 1906 in regards to the death of William Hoten, an inmate of the Michigan Home for the Feebleminded and Epileptic before a local court in the City of Lapeer. Findings of the inquisition were: "We find William Hoten came to his death from scalds received during a bath given by inmate Frank Vernon under the supervision of an attendant contrary to the rules of the institution."[24] Testimony revealed that William Hoten, an apparent paretic who was incontinent and non-communicative was bathed following soiling on Thursday evening September 6, 1906 during which he was scalded by hot water that resulted in a large area of second degree burns of the lower part of body. Despite fact the incident was reported to the Superintendent on Friday morning he did not see the inmate until Monday noon. Testimony further revealed that despite Rules and Regulations (APPENDIX A) to the contrary it had apparently been a common practice to allow inmates to bathe other inmates.

TRAINING OF ATTENDANTS--The first document regarding training schools for attendants in Michigan was from the Michigan Asylum for the Insane at Kalamazoo in the year 1894. It announced that on the evening of November 20th the training school for attendants graduated its first class of eleven. Instructions consisted of lectures by the medical officers, quizzes and practical instruction on the wards.[25]

Several years later, the Michigan Home for the Feebleminded and Epileptic reported that: "Our weekly lectures and training school

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[24] Inquisition on body of William Hoten before Benjamin F. Perkins, Justice of the Peace, September 20, 1906.

[25] _____, "Half Year Summary-Michigan," Journal of Insanity, Volume 51, January 1895, p. 244.

work has done much to improve the qualifications of those having the care of inmates, and infuse into them earnestness and faithfulness in their work. For the measure of the success of an institution of this character is very largely determined by the character and usefulness of the persons occupying subordinate positions."[26]

In 1904, the Board of Control reported that the training school was starting again and the attendance was large. Although not aiming to graduate a highly accomplished individual such as the best hospitals, "we do desire to raise the standards of competency of those in charge of our wards, and develop abilities in those desirable for advanced positions in the institution."[27]

The 1906 report related that attempts to maintain the training school for attendants and nurses had been most difficult due to the limited medical staff whose other duties often caused them to neglect the school. "Besides there is always some indifference unless the course is made compulsory; or encouragement given to those who meet the requirements of its two year course and get their diplomas by receiving some advance pay. Those who have been trained and are still in the employee of the institution are as a rule more capable of advancement than others, and have always proved valuable assistants, either in the routine of cottage work or in the work of the medical department."[28]

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[26] _____, Reports of Board of Control of the Michigan Home for the Feebleminded and Epileptic at Lapeer, 1896-1918, Lansing, Michigan: Robert Smith Printing Co., State Printers and Binders, 1900, p. 8.

[27] Ibid., 1904, p. 16.

[28] Ibid., p. 14.

The 1900 reference to weekly lectures and training school work, although not documented, was apparently like that announced for the Vineland Training School which is reproduced:

> The winter course of talks for the employees' class began last month. For several years at stated times we have held employees' meetings, at which matters of interest and importance of all employees were talked over. As the tenure of office of our employees has grown larger there has been expressed a desire to know more of the work than appears in the daily routine and this course of talks is in response to this demand. The season's course comprises twenty-eight lectures, as follows:

Feebleminded Children	The Superintendent
The Psychological Problem	Dr. Goddard
The Physical Care of Children	Dr. Patterson
Discipline	The Superintendent
The Use and Abuse of Schedules	Miss Morrison
What to Observe and How	Dr. Goddard
The Care of the Children	Miss Vernon
Responsibility	The Superintendent
Food	Miss Hutchinson
Business Relations	Miss Fallon
Entertainments	Miss Morrison
Economy and Property Rights	The Superintendent
Repairs and Industrial Work	Prof. Nash
Experiments	Dr. Goddard
Institutional Efficiency	The Superintendent
Clothing and Linen	Miss Vernon
Water and Food	Dr. Patterson
Suggestions	Dr. Goddard
Training	Miss Morrison
The Unseen Work	The Superintendent
Bathing, etc.	Dr. Patterson
The Farm and Dairy	Mr. Veale
The Significance of Little Things	Dr. Goddard
Punctuality	The Superintendent
Care and Tidiness of the Institution	Prof. Nash
Organization of the Institution	The Superintendent
Housekeeping and Homemaking	Miss Hutchinson
Ventilation and Sanitation	Dr. Patterson[29]

It is of interest to note that Professor Nash was the Band Master, Miss Vernon the Matron and Miss Morrison the School Principal. In

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[29] _____, "Winter Lectures," The Training School Bulletin, Volume 3, Number 33, June 1906, p. 88.

order to demonstrate the contents of the lectures, Dr. Patterson's talk, "The Physical Care of Children," is reproduced in APPENDIX B.

Focus on the training of attendants and nurses was a frequently mentioned subject in the literature of the era as is indicated by a publication of Delia E. Howe, M.D. in the initial issue of the Journal of Psycho-Asthenics. It concerned training schools for attendants. Dr. Howe stated that newly hired attendants were not capable of caring for the institutionalized feebleminded without training. They did not have a thorough knowledge of the laws of hygiene nor the principles of nutrition. Many could not properly bathe an inmate and not two per cent knew what massage meant. Not one in ten were able to observe and report symptoms with accuracy. Very few knew "the importance of the elimination from the body of its waste matter and recognized morbid appearances of the excreta."[30] Numerous other areas of deficiency were noted by the physician from the Fort Wayne, Indiana institution for the feebleminded.

Secondly, Dr. Howe advocated the need for the establishment of training schools in the institutions because adequate training "cannot be done with an occasional talk or by a book of rules."[31] The training school she recommended would be for a period of one to two years, similar to the training schools in the better hospitals with a principal, text books, didactic presentations of theory, clinical demonstrations, and supervised practice periods.

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[30]Howe, Delia E., "Training Schools for Attendants," Journal of Psycho-Asthenics, Volume 1, September, 1896, pp. 75-84.

[31]Ibid., p. 79.

During his tenure as President of the Association of Medical Officers of Institutions for the Feebleminded, Dr. W. A. Polglase made reference to attendant training. He pointed out that "advances in the methods of training and care of the defectives called for more skillful attendants and nurses, and a number of institutions had established training schools with commendable results.[32]

Evidence that training schools were highly developed is contained in publications of the day. "The Rome, New York, State Custodial Asylum Training School for Attendants for Men and Women"[33] was described in detail in the Journal of Psycho-Asthenics. The course of training covered two years of fifty-two weeks each. The first year was devoted to the preparation of attendants to provide physical care to the infirmed and enfeebled. The second year was concerned with preparing the attendants in the physical, mental, moral and industrial training of the feebleminded. To enter the school an applicant had to be twenty-one years of age and take a preliminary entrance examination in writing from dictation, punctuation and the fundamental operations of arithmetic. The curriculum content, number of hours of classroom lectures and practical training would have been sufficient to make a graduate eligible for certification by waiver as a Registered Nurse in Michigan (APPENDIX C).

In 1904, the Michigan State Nurses Association was formed and the constitution stated: "Object of this association shall be the

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[32]Polglase, W. A., "Presidents Address--Twenty-fifth Annual Convention of Association of Medical Officers of Institutions for the Feebleminded," Journal of Psycho-Asthenics, Volume 5, June 1901, p. 96.

[33]Bernstein, Charles, "Training School for Attendants for the Feebleminded," Journal of Psycho-Asthenics, Volume 11, 1906, pp. 31-43.

organization and registration of the graduate nurses of Michigan, the futherance of all means aiming to elevate the standard of the nursing profession, the establishment of professional reciprocity between nurses of Michigan and those of other states and countries, and acquiring statutes regulating the profession of nursing,"[34] After several unsuccessful attempts the Association was instrumental in having Act 319, Public Acts of 1909, Laws Governing Examination and Registration of Nurses passed. The law described a Registered Nurse by stating: "Within the meaning of this act, a State registered nurse is defined as one who, for hire or reward, nurses, attends and ministers to the sick and afflicted under the supervision and direction of a legally registered practitioner, and who has qualified for such calling or profession through a regular course of instruction and practice in a recognized training school for nurses connected with a hospital, sanatorium or State institution for the consumptive, insane or feeble-minded and compliance with the further provisions of this act." As is usual with licensure laws a waiver clause was contained in the law which allowed for a certificate of registration without examination to anyone who had diploma from a training school giving a two year course of training provided application be made before December 1, 1911.

The Michigan Board of Registration of Nurses issued in November 1910, a curriculum as a standard for the guidance of training schools for nurses which were the minimum of instruction required in order to comply with the law. (APPENDIX C.) In summary it provided for a full two years devoted to hospital training.

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[34]Letter from Mabel E. Smith, R.N., Executive Secretary, Michigan Board of Nursing, May 7, 1948.

The first two months was to be a probationary period which included instruction during the first two weeks in care of rooms, bed making, vital signs, bathing, feeding helpless patients and use of disinfectants. At the end of two weeks of instruction the probationer was placed on the wards to gain practical experience.

During the remainder of the first year forty-eight hours of lecture which included hygiene, bacteriology, anatomy, physiology and dietetics was required. Practical work included the learning and practicing of medical nursing procedures.

Thirty-nine hours of theoretical lectures on Surgery, Gynecology, Obstetrics, Pediatrics, Infectious Diseases, Nervous Disorders and Anesthetics were required of the senior class. Practical work focused on surgical, obstetrical and pediatric nursing as well as bandaging and methods of instruction.

All training was to be under supervision of the superintendent of nurses, her assistant or a senior nurse. It was suggested by the Board of Registration of Nurses that special hospitals affiliate with general hospitals; that lectures and classes be held during the day and that all training schools employ a graduate nurse to teach and supervise practical instruction.

The newly organized Board of Registration of Nurses soon discovered that many applicants for registration lacked theoretical knowledge of required subject matter and the appropriate skills in nursing procedures that the Board considered to be the minimum standards for a qualified nurse. They attributed these deficiencies to (1) meager equipment for successful teaching, (2) insufficient staff to afford the necessary drill in fundamental precepts, and (3) too

hasty selection of student nurses.[35] The Board felt it necessary for a representative to visit the training schools and help correct defects. As a result of this need the Nurse Practice Act was amended by Act 87 of the Public Laws of 1913 to include the following: "The Michigan Board of Registration of Nurses is hereby authorized to appoint and employ a registered nurse who has not less than five years' experience in nursing since graduation, three years of which have been spent as superintendent of a training school approved by said board, to act as a visitor and inspector of training schools for nurses, to the end that the rules and regulations adopted by said board may be promoted and upheld throughout the State."[36]

First indication that the amended Nurse Practice Act had an effect on the institutions for the insane and feebleminded is in the remarks of Dr. Noble, Medical Superintendent of the Kalamazoo State Hospital who reported that the State Board of Registration of Nurses had required that pupil nurses at his institution have six or nine months work in a general hospital in addition to the training they then received. As a result of the new requirements the Board of Trustees voted to extend the course of the school to three years and to add to the usual requirements for graduation a certificate of nine months work in an affiliated hospital.[37]

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[35] McCabe, Miss, "The Development of Nursing Legislation in Michigan," (Unpublished and undated excerpts from the History of Nursing in Michigan obtained from Michigan State Board of Nursing), p. 1.

[36] Michigan Public Law 319 of 1909 as amended by Section 8 of Public Law 87 of 1913.

[37] Noble, A. I., "Report of Kalamazoo State Hospital," Proceedings of the Meeting of the Joint Board of Trustees of the State Hospitals of Michigan, Lansing, Michigan: Wynkook Hallenbeck Crawford Co., State Printers, 1915, p. 7.

Early records of the Board of Registration of Nurses revealed that they exercised control over the training schools of the state. In November of 1915 the Board "moved and voted that the Secretary be instructed to write to Dr. Christian, Medical Superintendent at Pontiac State Hospital in regards to changing the wording of 'Training School for Attendants' on the diploma for graduate nurses."[38]

At another Board meeting it was "moved by Dr. Peterson that in as much as there had been no reply to the communication with the Pontiac State Hospital it be understood that there is no longer a training school connected with the hospital. Carried."[39]

Kalamazoo State Hospital was also sanctioned by the Board because a graduate of their training, who had made application for examination was noted to have no practical experience in Operating Room and Obstetrical Nursing. "The Secretary was requested to write to Miss Muff, the Superintendent of Kalamazoo Asylum Training School advising her that the Board felt it necessary for their nurses to have practical experience in these services."[40]

Due to a "relative large number of failures in the last examination" the Board, in 1919, instructed the Secretary to again communicate with the Kalamazoo State Hospital and urge them to make a special effort to improve the class work in their training school.[41]

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[38] _____, "Record of Proceedings of the Michigan Board of Registration of Nurses (Unpublished document obtained from Michigan State Board of Nursing), November 5, 1915.

[39] Ibid., May 13, 1917.

[40] Ibid., May 16, 1916.

[41] Ibid., November 5, 1919.

Records of the Board of Registration of Nursing showed that in March of 1920 training schools for nurses were functioning in only three of the State Hospitals, namely, Kalamazoo, Newberry and Traverse City. Total enrollment in the three schools was seventy-three and the data indicated that students must be high school graduates to enter and that a cash allowance as well as uniforms were provided to the pupils.

In 1921, the Nurse Practice Act was again revised. The war, the influenza epidemic and the shortage of nurses resulted in provisions being made for the training of attendants. The Board provided for the examination of trained attendants who must be at least twenty years of age, have an eighth grade grammer school education and possess a certificate showing graduation of at least nine months of training in a hospital or sanitarium approved by the Michigan Board of Registration of Nurses and Trained Attendants.[42] The enactment of this amendment was to have impact on the future status of attendant training in the State Hospitals of Michigan.

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[42]Act 318, Michigan Public Acts, 1909, as amended by Act 87, Laws 1913, and Act 255, Laws 1921, Section 4.

CHAPTER IV

PERIOD OF MICHIGAN STATE HOSPITAL COMMISSION

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PERIOD OF MICHIGAN STATE HOSPITAL COMMISSION (1923-1945)

The belief that the feebleminded had strong criminal and anti-social tendencies began to abate. In 1924, Fernald pointed out that the development of such concepts had been based on past studies of the only known large groups of defectives of the period, namely, "those who had got into trouble and were in institutions, who were largely of the hereditary class and had behaved badly and were shiftless and lazy."[1] Ignored were the feebleminded from good homes without troublesome traits. Studies of those in special school classes, the alleged feebleminded identified by the World War I tests and other community based individuals demonstrated that the earlier generalizations concerning the feebleminded were not warranted. It was discovered that many came from average homes of all socio-economic levels with industrious, well behaved parents. "The clinical history of many suggested that infective, inflammatory or other destructive brain disease in infancy was the cause of the mental defect. Other types of defect are probably non-hereditary--the Mongolian, the Cretin, the Syphilitic, and Traumatic, etc."[2]

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[1] Fernald, Walter E., "Thirty Years Progress in the Care of the Feebleminded," The Journal of Psycho-Asthenics, Volume 29, June, 1924, p. 212.

[2] Ibid., p. 213.

The early 1920's was a period of changing attitudes. There was beginning awareness that the need to protect the general public from the deviant had been over-stressed and the obligations society had for the well being of the feebleminded had been overlooked. Realization that all of the intellectually impaired could not be segregated in institutions gradually gained acceptance with the resulting development of some local school classes. However, the residual effect of the previous beliefs that the feebleminded were evil, dangerous and the like would continue for a long time. When an attempt to declare Virginia's sterilization law unconstitutional reached the United States Supreme Court in 1927, Justice Oliver W. Holmes upheld the law stating: "We have seen more than once public welfare call upon the best citizens for their lives. It would seem strange if it could not call upon those who already sap the strength of the State for these lesser sacrifices in order to prevent being swamped with incompetents."[3]

Despite the realization that institutionalization was no longer necessary for the bulk of the feebleminded, institutions continued to grow although the rationale for same no longer existed. Wolfensberger[4] noted that institutional growth evolved dynamically from 1847 to about 1925 as ideas and innovations continuously followed one another. Logically, community based special services should have developed after the first quarter of the twentieth century but many factors inhibited

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[3] Nowrey, Joseph C., "A Brief Synopsis of Mental Deficiency," American Journal of Mental Deficiency, Volume 55, January, 1945, p. 354.

[4] Wolfensberger, Wolf., Changing Patterns in Residential Services for the Mentally Retarded, Part IV, History and Development, Chapter 5, The Origin and Nature of our Institutional Models, pp. 128-131. Robert B. Kugel and Wolf Wolfensberger (Editors), U.S. Government Printing Office, Washington, D. C., 1969.

such movement: (1) The general public had been well indoctrinated into the menace of leaving the feebleminded in the community, (2) The depression required the efforts of social agencies for factors essential to the economic survival of the nation, (3) World War II diverted attention and concern from social problems to those necessary for gaining victory for the country, (4) The prevalence, in professional groups, of the belief that the individual intellectual level was unalterable, and (5) The discoveries of new treatment methods in mental health diverted attention of workers from the field of mental retardation.

Late in the period it became evident that competent researchers began to breakdown the concept of the homogeneity of the feebleminded by discovering group differences among them. The work of Werner and Strauss at Wayne County Training School, of Jervis at Letchworth Village and of Doll at Vineland began to command respect and again awaken interest in the field.[5]

Michigan reflected trends found in the country in general. Act 285 of the 1929 Public Laws of Michigan, now amended, an act to prevent procreation of feebleminded and insane persons, moral degenerates and sexual perverts; and to authorize and provide for the sterilization of such persons and payment of the expenses thereof, was passed by the Legislature. By 1945, the population of the Lapeer State Home and Training School was more than 4000 and sixteen dormitory buildings had been built since 1923. In addition to the above, Wayne County Training School was opened in 1926; the Federal Government Indian School

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[5]Kanner, Leo, "The Exoneration of the Feebleminded," American Journal of Psychiatry, Volume 98, 1941, p. 27.

became the Mt. Pleasant State Home and Training School in 1934; The Michigan Children's Village (state orphanage) became the Coldwater State Home and Training School in 1937 and a unit for the feebleminded was established at the Newberry State Hospital.

INSTITUTIONAL DESCRIPTION--Act 151 of the Michigan Public Laws of 1923 entitled "The Hospital Act for Mentally Diseased Persons" created a State Hospital Commission, and provided for the transfer of the powers and duties then vested in the Boards of Control of the individual institutions. The Commission was directed to revise and consolidate the laws organizing the hospitals for the mentally ill and homes and schools for the mentally handicapped and epileptics and to regulate and provide for the care and management of the institutions.

Rules and Regulations of the Commission provided for the appointment of one or more commissioners as a visiting and advisory committee for each institution. Each visiting commissioner was required to make a thorough inspection of the assigned institution at least monthly. Responsibility for the day to day operation of the institution was assigned to the Medical Superintendent.[6]

One of the first changes brought about by the newly organized State Hospital Commission was the division of the work of Attendants and Nurses into two shifts a day. In 1934, the unpublished minutes of the Commission indicated that henceforth the minimum wage for employees was to be $50.00 per month and that no employee was to be required to work more than fifty-four hours per week. September, 1936 action of the Commission resulted in the awarding of two weeks vacation with pay

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[6] _____, Rules and Regulations of the Michigan Hospital Commission, Lansing, Michigan: Boys Vocational School Press, 1931.

per year to the institutional staffs and in June, 1939 a cash commutation allowance in lieu of maintenance was granted. Maintenance was to be considered worth $35.00 per month. The term mentally handicapped as used in Act 151 was defined as follows: "The term mentally handicapped shall include morons, idiots, imbeciles and those as to whom congenital defects have produced the same deficiency."[7]

In 1938, the Michigan Legislature changed the State Constitution to provide for the establishment of the Michigan Civil Service. Through a Commission, appointed by the Governor with the consent of the Senate the Civil Service Department was charged with the responsibility of developing a merit system that would provide equal employment to all and bring about the demise of the spoils system so common to governmental politics. Although the immediate impact of the Civil Service Department was minimal, with the passing of time, it entered in all phases of conditions of employment within the institutions.

The first Social Worker was appointed at the Michigan Home and Training School in October, 1923. In the beginning, the lone worker supervised fifty parolees and the fifty-five patients, male and female, who did day work in downtown Lapeer, as well as compile the family histories of patients for use by the Medical Staff. In 1945, an enlarged staff, supervised five hundred patients on parole, over 2000 monthly day work assignments in Lapeer and the surrounding area; besides coping with the problems of Selective Service, Income Tax, Social Security, and Ration Point Stamps.[8]

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[7] _____, State of Michigan Mental Health Statutes, Lansing, Michigan: Legislative Service Bureau, 1969, p. 41.

[8] Owsley, Ada and Beryl Bishop, "Social Service," Lapeer Employees' Reporter, Volume 5, 1945, p. 14.

An Employees' Club was established in 1923. The nearest stores and entertainment were three miles away in Lapeer and transportation was just about non-available. The vast majority of employees lived on the grounds, were prohibited from visiting in one anothers rooms and had extremely limited facilities for social activities available to them. Dr. H. A. Hayes, Medical Superintendent, saw the need and fostered the founding of the "Club Store." The basement under the Chapel was excavated and an employee area established. Two bowling alleys were installed, the club room furnished with comfortable furniture, pool tables, piano and other items that provided many hours of recreation for the employees. Profit from the store which sold to both patients and employees was pro-rated to aid the Patients' Benefit Fund and maintain the Employees' Club.[9]

By 1934, the School Department reached a peak enrollment of seven hundred and eighty-three students and a staff that included a principal, nineteen teachers, an accompanist as well as recreational specialists. Classes met in five different buildings and training was offered in academic work from sense training through eighth grade; manual training including simple hand work, fine arts, sewing, cooking, weaving, woodwork and printing was another part of the total curriculum. Recreational activities included school parties, mixed dances, programs, band concerts, ball games and other play ground activities.[10]

TRAINING OF ATTENDANTS--By 1923, the Michigan Board of Registration of Nurses and Trained Attendants had defined the practice

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[9]Prather, V. A., "Employees Club," Lapeer Employees' Reporter, Volume 5, p. 11.

[10]Niblack, A., "The School Department," Lapeer Employees' Reporter, Volume 5, 1945, p. 6.

of nursing by a trained attendant as caring for the ill, injured and infirmed in accordance with education and training which gave the practitioner a lesser degree of specialized skill, knowledge, education and training than that required to practice as a registered nurse. The Board required that a trained attendant practice nursing only under the direction of a registered nurse, licensed physician or dentist.

In 1928 the requirements for "Schools for Trained Attendants" was issued by the Michigan Board of Registration of Nurses and Trained Attendants (APPENDIX D). The first requirement stated that training schools for attendants could not be established in hospitals or sanitoria that had training schools for nurses. Secondly, the course of training could not be less than nine months nor longer than one year. The school had to be conducted by a registered nurse qualified to teach elementary practical nursing procedures and preparation of diets for the sick. Uniforms were required to be plain and not duplicate those of students in accredited training schools for nursing and were not to include nurse's cap.

The minimum course of instruction for the "Schools for Trained Attendants" required at least six months spent in the actual care of patients and one hundred thirty-five hours of instruction which was to consist of practical nursing demonstrations, housekeeping, anatomy and physiology, dietetics and ethics. Textbooks recommended would today be classified as home nursing, practical nursing and first aid.

Regulations of the Michigan Board of Registration of Nurses and Trained Attendants prohibited Kalamazoo and Traverse City State Hospitals from having accredited Schools for Trained Attendants because they had Training Schools for Nurses. Newberry State Hospital

was notified, in a letter to Mrs. Sheldon, the Superintendent of Nurses, "that at a meeting of the Board of Registration of Nurses and Trained Attendants on October 26, 1927 the trained attendant course was formally approved."[11] The letter went on to state that the approval was back dated to October 1, 1926 and cautioned the hospital not to exceed the recommendation that students work more than fifty-four hours per week.

A letter from the Newberry State Hospital to the Board of Registration of Nurses and Trained Attendants in early 1930 stated: "Our course for Trained Attendants did not turn out very well last fall, and we discontinued it. We had only two girls finally decide to take the course, and the doctors here did not think it worth while to spend so much time on so small a class."[12]

Contained in the August 13, 1932 minutes of the Michigan Board of Registration of Nurses and Trained Attendants was the decision that the course given at Pontiac State Hospital was not considered equivalent of the standards required for trained attendants. It recommended that the Hospital secure an adequate teaching staff, improve its housing facilities and give post-graduate and affiliate courses in psychiatric nursing in place of the attendant training.

There is no further evidence to indicate that the other institutions under the jurisdiction of the State Hospital Commission ever attempted to gain approval of the Board of Registration of Nurses and

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[11] Letter from Helen de Spelder Moore, R.N., Secretary, Michigan Board of Registration of Nurses and Trained Attendants, November 1, 1927.

[12] Letter from Mrs. M. R. Barringer, Superintendent of Nurses and Attendants, January 24, 1930.

Trained Attendants for the training they were conducting. Files of the Board of Nursing revealed that the attempts to establish training courses for attendants were unsuccessful. Closure of the last approved school, Mercy Hospital at Manistee occurred in 1952.

The Michigan Hospital Commission, as directed by the newly enacted 1923 law, established the responsibilities of the Medical Superintendent. In regards to the training of personnel the Medical Superintendents were directed to "establish and supervise a training school for attendants or nurses, or both, at each of the several institutions under rules and regulations of the institution as approved by the Hospital Commission.[13]

P. C. Robertson, Medical Superintendent of the Ionia State Home surveyed the training of attendants being conducted in the institutions responsible to the Michigan State Hospital Commission in early 1936. Training at the nine institutions was very much alike in that classes were held in the evening off-duty hours and it was expected that all would attend the course and pass the examination if they had any expectation of either promotion or salary increase. The majority of classes were lectures given by physicians on medical subjects such as Bacteriology, Asepsis, Social Diseases, and Obstretics.[14] Other professional personnel lectured in the areas of their specialization. There was very little or no time devoted to demonstrations or the direct care procedures of the institutions population. The appropriate manner of caring for patients was learned by observation, trial and

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[13]State of Michigan Mental Health Statutes, op. cit., p. 13.

[14]P. C. Robertson, M.D., "Attendant Lecture Series," a personal file.

error or incidental training by ward and cottage personnel. A sample lecture and the training program outline of the Pontiac State Hospital appears in APPENDICES E and F.

The Michigan State Hospital Commission, in late 1936, appointed a committee of Medical Superintendents, Dr. R. R. Sheets of Traverse City Chairman, Dr. R. A. Morter of Kalamazoo and Dr. O. R. Yoder of Ypsilanti to investigate the needs for the training of nurses and attendants. Their findings were gathered from data obtained by solicitation from a number of State Hospital Departments and individual institutions.[15] At that time forty-eight state hospitals in the United States had undergraduate schools of nursing, a smaller number had either affiliate or postgraduate nursing courses. They also found that training for attendants was quite prevalent, although not universal.

The Committee recommended that State Hospitals should not have training schools for nurses unless there were insufficient schools in the community in which the hospital was located. It further recommended that all State Hospitals should be required to conduct a training school for either affiliate or postgraduate students in the area of psychiatric nursing. Apparently this recommendation was acted upon because in 1939 Kalamazoo State Hospital closed its training school and the training school at Traverse City became more closely associated with the Munsen Memorial Hospital. Also stated was that the Committee deemed it essential that all institutions in the group participate in a program of nurse training and that permission to not participate be

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15 _____, "Report of Committee on Nurse's and Attendant's Training in Michigan State Hospital Group," December 1, 1938, an unpublished report obtained from files of Ionia State Hospital.

granted by the Hospital Commission only. Despite this recommendation there is no evidence that any of the State Homes and Training Schools, (Lapeer, Mt. Pleasant and Coldwater) all members of the hospital group, ever had affiliate nurse programs. An insight into prevailing attitudes of the time may be gained from the curriculum for the affiliate nurse programs. One study unit was titled Psychiatric Disorders, Functional Reaction Types which were described as conditions in which insufficient organic pathology was demonstrable. Types of cases considered essential for the adequate experience of the student included manic-depressive and schizophrenic psychoses, involutional meloncholia and the psychoneuroses. Types of cases desireable but not essential for the adequate experience of the student included psychoses with psychopathic personality and mental deficiency.

In regards to the training of nurses the Committee concluded by stating they were of the opinion that the training of nurses was a serious undertaking and the utmost care should be exercised in working out plans and organization that would approach as nearly as possible the ideal.

Concerning the training of attendants the Committee recommended that all newly employed attendants be given a comprehensive course of instruction to better prepare them for the responsibility of caring for mental patients. The recommended curriculum consisting of thirty hours of lecture and twelve hours of demonstrations is reproduced:

SUGGESTED SUBJECT MATTER FOR LECTURES

History of the Treatment of Mental Disease . . . . 1 hour
The Modern Mental Hospital . . . . . 1 hour
Hospital Ethics & Attitudes Toward the Public. . . 1 hour
Anatomy. . . . . 2 hours
Physiology . . . . . 2 hours

First Aid	3 hours
Causes of Mental Disease	2 hours
Classification of Mental Diseases	2 hours
Treatment of Mental Diseases	3 hours
Nursing Care of the Mentally Sick	3 hours
Dietetics and Nutritional Care of Mental Patients	1 hour
Contagious Diseases	1 hour
Habit Training and Socialization Programs	2 hours
Occupational Therapy	2 hours
Recreational Therapy	2 hours
Hospital Economics	1 hour
Correlation of Hospital Activities	1 hour
Total:	30 hours

The outline for the twelve practical demonstrations is given below:

1. Demonstration and Instruction - Hospital Housekeeping -- 1 hour

    1. Ventilation, temperature and lighting of wards in general.
    2. Special attention in regard to these at meal hours and at other times when wards are empty.
    3. General and special cleaning of wards and rooms.
    4. Care and cleaning of scrubbed and of polished floors.
    5. Care of brooms, brushes, mops, pails and other ward utensils.
    6. Care and cleaning of tile, enamel, marble and metal work.
    7. Care and cleaning of windows.
    8. Care and cleaning of stairways, halls, clothes, and dust chutes.
    9. Cleaning, ventilating and general care of toilet rooms, laboratories and baths.

2. Demonstration and Instruction -- 1 hour

    1. Care, airing and cleaning of bedsteads, mattresses, pillows and bed linen.
    2. Opening bed for ventilation and at night.
    3. Care and cleaning of furniture, rugs and carpet.
    4. Care of wardrobes, bureaus, etc., and their contents, in patients' rooms.

3. Demonstration and Instruction -- Care of clothes and linen rooms -- 1 hour

    1. Marking hospital and private clothing.
    2. Marking ward linen.
    3. Arranging clothing and ward linen.

4. Mending clothing and ward linen.
5. Care of footwear.
6. Sending to and receiving from the laundry.
7. Making requisitions and receipting for ward supplies.

4. Demonstration and Instruction -- Toilet, bath and clothing -- 1 hour

1. Attention to patients' toilet.
2. Special attention to hair, teeth and nails.
3. Shaving.
4. Keeping patients neat and tidy.
5. Spray and tub baths.
6. Changing soiled and wet clothing.
7. Dress and undressing of apathetic, resistive and irritable patients.
8. Preparation for bed.
9. Care of patients' clothing at night.

5. Demonstration and Instruction -- Bed Patients -- 1 hour.

1. Changing bedding with patient in bed.
2. Changing patient's clothing with patient in bed.
3. Protection of patient from exposure and draughts.
4. Setting patient up in bed.
5. Setting patient out of bed on commode and chair.
6. Care of back and other parts exposed to pressure.
7. Care of cupboards and medicine cabinets.
8. Care and use of disinfectants and other poisonous ward solutions.

6. Demonstration and Instruction -- Food Service -- 1 hour.

1. Getting patients ready for meals and attention to patient during and after eating.
2. Proper food for the aged, paralyzed and very demented.
3. Precautions against scalding and choking.
4. Feeding the feeble and demented.
5. Training the untidy to better habits of eating.
6. Tray service.
7. Feeding patients in bed.

7. Demonstration and Instruction -- Exercise -- 1 hour.

    1. Getting patients ready for outdoor exercises; guarding and caring for patients doing exercise.
    2. Indoor and outdoor games.
    3. Guarding against accidents and escapes while exercising.
    4. Guarding against suicide while exercising.

8. Demonstration and Instruction -- Occupation and Amusements -- 2 hours.

    1. Indoor occupations.
    2. Management of the idle and eccentric.
    3. Management of working party.
    4. Precautions against accidents and escapes while employed.
    5. Proper treatment of a patient at work.
    6. Clothing, shoes, hats and mittens.
    7. Toilet facilities.
    8. Rest.
    9. Exposure to heat, cold and wet.
    10. Indoor and outdoor games.
    11. Reading.
    12. Conversation.
    13. Music.

9. Demonstration and Instruction -- Management of Patients -- 1 hour.

    1. Tactful, patient, gentle, firm, reasonable methods.
    2. Management of emotional outbursts.
    3. Management of depressed conditions and agitations.
    4. Management of delusions.
    5. Precautions against suicide.
    6. Management of violence, destructiveness, mischievous tendencies.
    7. Physical control, hospital regulations -- methods under various conditions.

10. Demonstration and Instruction -- Management of Patients -- 1 hour.

    1. Care of the aged, feeble and demented walking cases.
    2. Attention to suitable clothing, underwear, night clothes and footwear.
    3. Changing of soiled and wet clothing.
    4. Management of incontinence.
    5. Exercise in and out of doors; guarding against exposure, over-exertion.

6. Rest during the day.
7. Suitable and properly served food.
8. Guarding against fractures and other injuries.

11. Demonstration and Instruction -- Night Duty -- 1 hour.

1. Attention to quiet moving and speaking.
2. Ventilation, heating, and lighting of wards and rooms.
3. Method of systematically observing patients.
4. Proper distribution of day clothing.
5. Night clothing of patients.
6. Guarding against exposure and draughts.
7. Getting patients out of bed. Management of incontinence.
8. Precautions against accidents, escapes and suicides.
9. Action in case of fire and other emergencies.
10. Keeping night charts, records and reports.

Total: 12 hours[16]

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[16]"Report of Committee on Nurses and Attendant's Training in Michigan Hospital Group," op. cit., pp. 2-4.

CHAPTER V

PERIOD OF MICHIGAN DEPARTMENT OF MENTAL HEALTH

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PERIOD OF MICHIGAN DEPARTMENT OF MENTAL HEALTH (1945-1973)

In the United States, the conclusion of World War II again brought into focus problems that had been cast into the background during the depression and the war years. In 1945 the provisions for the care of the mentally retarded were just about the same as they had been in the late 1920's.

The first significant action was brought about by the newly organized National Association for Retarded Children made up primarily of parents of mentally retarded. They were very much disenchanted with the efforts being made to meet the needs of their handicapped off-springs in institutions and in the community.

In Michigan, the State Association for Retarded Children was initially concerned with the difficulty and the time delay faced in having their handicapped youngsters admitted to the retarded institutions. Acting as a lobby group and enlisting the aid of newspapers and other media, they embarked upon a campaign to eliminate the large waiting list which resulted in the construction of the Plymouth State Home and Training School, the acquisition of the station hospital at Fort Custer and the utilization of the tuberculosis sanitoria at Gaylord and Howell for the institutional care of the mentally retarded. These additional installations made another 4300 beds available

for institutional care but in actuality it failed to eliminate the waiting list.

During the period 1950-1965 the Michigan Association for Retarded Children as well as the National Association grew in size and influence. Along with a number of professional personel who were engaged in the care of the mentally retarded they managed to begin a movement that would provide the retarded with more equal opportunities for education and training at the local level. The State Department of Public Instruction attempted to increase the number of classes for the educable and trainable by providing for varied types and amounts of added reimbursement to school districts that conducted special education classes; made provisions for the certification of special education teachers and stimulated the State's institutions of higher learning to increase their course offerings and to develop curricula for special educators. In 1957, the State Legislature enacted Public Law 148, the "County Trainable Bill" which allowed intermediate school districts to organize trainable classes when local districts were unable to do it. Public Acts 265 of 1955 and 191 of the 1963 Michigan Legislature made it possible for local and intermediate school districts to vote millage for special education purposes.

Toward the end of this period, the parents of the retarded and others began to take a critical look at the institutions wherein their children resided and began to voice dissatisfaction with what they saw. One such expression of discontent was a television documentary "A Wind Is Blowing" produced and shown by Channel 12, WJRT-TV Flint, which was an expose of the overcrowding, poor equipment and personnel shortages at the Lapeer State Home and Training School. However the impact of

the many efforts of the decade had minimal influence in resolving the problems of correcting the existing deficiencies in the services provided for the mentally retarded.

On October 17, 1961, John F. Kennedy, the President of the United States appointed a Panel, headed by Leonard W. Mayo, which was mandated to prepare a national plan to combat mental retardation. Three hundred and sixty-four days later the Panel sent to the President "A Proposed Program for National Action to Combat Mental Retardation."[1] An accompanying letter from Dr. Mayo stated that the Panel has "devoted the intervening months to carrying out the assignment and have prepared for your consideration recommendations concerning research and manpower, treatment and care, education and preparation for employment, legal protection and development of federal, state and local programs."[2] The Panel's recommendations were transformed into a message the President delivered to the Congress on February 5, 1963 in which he stated: "It is my intention to send shortly to the Congress a message pertaining to this Nation's most urgent needs in the area of health improvement. But two health problems--because they are of such critical size and tragic impact, and because their susceptibility to public action is so much greater than the attention they have received--are deserving of a wholly new national approach and a separate message to the Congress. These twin problems are mental illness and mental retardation."[3] The

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[1] _____, A Proposed Program for National Action to Combat Mental Retardation, Washington, D. C.: United States Government Printing Office, 1962.

[2] Letter from Leonard W. Mayo, Chairman of the President's Panel on Mental Retardation, October 16, 1962.

[3] Message from the President of the United States Relative to Mental Illness and Mental Retardation, 154 Session, 88th Congress, Document No. 58, 1963.

message continued, pointing out that since the earliest days of the Nation the Federal Government had assumed a major role in alleviating health problems beginning with the Public Health Service and more recently with the research work of the National Institutes of Health. The success of these undertakings had overcome many contagious and physical diseases but progress in the area of mental disabilities had not made any significant advancement. The tremendous expenditure of tax dollars was mentioned as well as the waste in human resources and the anguish suffered by both the afflicted and their families. The Presidential message continued as follows:

> This situation has been tolerated for too long. It has troubled our national conscience but only as a problem unpleasant to mention, easy to postpone, and despairing of solution. The Federal Government, despite the nationwide impact of the problem, has largely left the solutions up to the States. The States have depended on custodial hospitals and homes. Many such hospitals and homes have been shamefully understaffed, overcrowded, unpleasant institutions from which death too often provided the only firm hope of release.
>
> The time has come for a bold new approach. New medical, scientific, and social tools and insights are now available. A series of comprehensive studies initiated by the Congress, the executive branch, and interested private groups have been completed and all point in the same direction.
>
> Governments at every level--Federal, State and local-private foundations and individual citizens must all face up to their responsibilities in this area. Our attack must be focused on three major objectives.[4]

The first objective was prevention. The President stated that quickly activiated programs in general health, education, welfare and urban renewal could make a major contribution in overcoming adverse

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[4] Ibid., pp. 2-3.

social and economic conditions that would result in reduction of mental retardation. Providing better medical care, nutrition, housing and health education could also aid in prevention. Programs of comprehensive maternal and infant care were also needed. Cultural and educational deprivation that resulted in mental retardation would be decreased by requiring that ten per cent of proposed Federal Aid for elementary and secondary education be committed by each State to special project grants designated to stimulate and make possible improved educational opportunities in slum and distressed areas, rural and urban.

The development of desperately needed community services was cited as the second objective. The message to Congress continued: "We must move from the outmoded use of distant custodial institutions to the concept of community-centered agencies that will provide a coordinated range of timely diagnostic, health, educational, training, rehabilitation, employment, welfare, and legal protection services. For those retarded children who cannot be maintained at home by their own families, a new pattern of institutional services is needed. The key to the development of this comprehensive new approach toward services for the mentally retarded is twofold. First, there must be public understanding and community planning to meet all problems. Second, there must be made available a continuum of services covering the entire range of needs."[5]

To stimulate public interest and to develop comprehensive plans the President recommended that Congress enact legislation to establish

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[5]Ibid., pp. 10-11.

a program of special project grants to the States for financing reviews of needs and programs in the field of mental retardation. To assist States and local communities to construct and activate facilities the surveys justify and plan it was further recommended that Congress authorize matching funds for the construction of public and other non-profit facilities, including centers for comprehensive treatment, training and care of the mentally retarded.

It was further recommended that there be developed facilities that would increase the role of qualified universities in providing services to the retarded and the training of specialized personnel needed to effectively implement the multitude of programs being proposed. Also, vocational training, youth employment and vocational rehabilitation programs that would help release the untapped potentialities of mental retardates needed to be developed.

The third major objective on which the President placed emphasis was research. He said the greatest challenge of mental retardation was to discover the causes and the methods of successful treatment. This would require the expansion of our scientific knowledge which could only be accomplished by the training of medical, behavioral and other professional specialists. In order to provide for additional research into the "complex mysteries of mental retardation"[6] the President recommended that legislation be passed to authorize the establishment of centers for research in human development where clinical, laboratory, behavioral and social science research could be carried out on an interdisciplinary basis.

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[6]Ibid., p. 13.

Congress reacted favorably to President Kennedy's message and on October 31, 1963 passed the "Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963"[7] which provided "assistance to the States in combating mental retardation through grants for construction of research centers and grants for facilities for the mentally retarded and assistance in improving mental health through grants for the construction of community mental health centers and for other purposes."[8] This Act also made available funding for State planning, for training of teachers of the mentally retarded and for research and demonstration projects in education of handicapped children.

The interest of President Kennedy in the mentally retarded and the commitment of President Johnson to continue the course of action just getting underway at the untimely death of President Kennedy created a level of interest among parents, professionals and the general public that was more intense than the action Samuel G. Howe generated more than a century ago.

In 1968 the President's Committee on Mental Retardation in its second annual report, stated that meaningful change had come into lives of the nations' mentally retarded in the decade of the 1960's.[9] However, the report continued, there is a long way to go and much to do before services for the retarded are complete and equal to the

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[7] U.S. Congress, Senate, Mental Retardation Facilities and Community Mental Health Centers Construction Act, S. 1576, 88th Congress, 1963.

[8] Ibid., p. 1.

[9] _____, MR 68, The Edge of Change, Washington, D. C.: U.S. Government Printing Office, 1968.

opportunities available to his peer with average intelligence. To demonstrate the progress being made in this country three developments were cited as being of high significance. They were:

> Popular and professional acceptance of the mentally retarded as human beings who can grow and learn to make the most of their abilities.
>
> Agencies reappraisal of their missions and methods in light of new and different human needs to be served. This reevaluation often painful, is bringing new patterns of social action and citizen participation in community affairs.
>
> Recognition of mental retardation program development as an inescapable part of the response to critical national issues such as poverty and deprivation, city planning and renewal, manpower training and use, education policy, population study and human resources planning.[10]

In regards to continued difficulties the President's Committee reported that there is still a need for additional interest and expertise in mental retardation on the part of professionals in the fields of health, education, social work, psychology and others. Also, for the most part, the institutionalized retarded continue to be cared for in custodial care environments. And most significantly, "the conditions of life in poverty--whether in an urban ghetto, the hollows of Appalachia, a prairie shacktown or an Indian reservation--cause and nuture mental retardation."[11]

The momentum started by the Kennedy Administration and the continued support of federal programs for the mentally retarded during President Johnson's tenure was enhanced by Public Act 91-517 of 1970, the Developmental Disabilities Act. This legislation, enacted during

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[10] Ibid., p. 1.

[11] Ibid., p. 19.

the Nixon Administration, provided program support for the cerebral palsied, epileptic and neurologically damaged as well as the mentally retarded.

Events in Michigan have closely followed national trends. Public Act 54 of the 1963 Legislature, known as the Community Mental Health Act, made it possible for local governmental units to develop services for the mentally ill and the mentally retarded with seventy-five per cent of the cost being paid by the State. This furthered the development of Child Guidance Clinics and Adult Mental Health Clinics but did little or nothing for the mentally retarded until the 1970's. The Governor appointed the Directors of the Departments of Public Health, Mental Health, Education, Social Welfare and Vocational Rehabilitation as the Governor's State Interagency Coordination Committee to develop a plan for State action to provide services for the mentally retarded and to bring about coordination of the efforts of the several departments. The Department of Mental Health made provisions for any local governmental or non-profit citizens group to open Day Care Centers and/or Adult Activity Centers for the community based mentally retarded who were not eligible for school programs, independent employment or sheltered workshop placement on a one hundred per cent funding basis as an alternate to institutionalization. The Institute for the Study of Mental Retardation was established at the University of Michigan under the direction of William M. Cruickshank.

Clustered together from 1969 onward are several other events that demonstrate a continuance of the momentum originated by President Kennedy in 1963. E. Gordon Yudashkin, M.D. was appointed by the Governor to be the Director of the Department of Mental Health

after achieving great success in returning the mentally ill to the community after brief periods of hospitalization at the Northville, Michigan, State Hospital. As Department Director, Dr. Yudashkin caused the more capable institutionalized retardates to be moved into community placements more consistent with their needs and more compatable with their human rights. He also brought pressure on the Community Mental Health Programs (Act 54 Boards) to devert some of their resources and efforts to the successful community placement of the retardates by aiding in the development of suitable living facilities, activity centers and sheltered workshops.

Effective September 1, 1973 Michigan school law makes it mandatory for local and intermediate school districts to provide for the education and training of all handicapped persons up to the age of twenty-five years. Prior to the passage of this legislation which came about as a result of a state-wide referendum providing educational services to the handicapped had been permissive and many school districts had little or no provisions for the education of the retarded and other handicapped persons.

Executive Order 11 of 1973, signed by Governor William G. Milliken on October 24 states that the "statutory authority, powers, duties, functions and responsibilities of the Michigan Department of Social Services, the Michigan Department of Public Health, the Michigan Department of Mental Health, the Indian Affairs Commission, the Division of Vocational Rehabilitation, the Office of Services to the Aging and Commission on Services to the Aging, the Michigan Economic Opportunity Office, the Manpower Planning Council and Emergency Employment Act Program, the Office of Health and Medical Affairs and

the Coordinated Child Care Council are transferred to the Department of Human Services effective January 1, 1974."[12] The reorganization is expected to make the delivery of human services more efficient. In his announcement of the change the Governor "made special mention of the need to improve community placement programs. An attempt is underway to solve the problems which have emerged as we move selected patients from large institutions for the mentally ill and mentally retarded to smaller community facilities."[13] The major objective in providing human services is to eliminate the underlying causes of dependency, whether economic, social, educational or medical and the reorganization is intended to stop the duplication of effort or the waste of resources which can contribute to dependency.

INSTITUTIONAL DESCRIPTION--Act 271 of the 1945 Michigan Legislature established a Department of Mental Health and provided for the transfer to said Department the powers and duties of the State Hospital Commission. The Act required that the Director, appointed by the Governor, be a psychiatrist certified by either of the boards of psychiatry or neurology. A State Advisory Council on Mental Health Services also appointed by the Governor was another provision in the legislative action that was intended to centralize and make more efficient the relatively independent functioning institutions for the mentally ill and the mentally retarded.

The reorganization that resulted from the establishment of the Department of Mental Health provided for a group of specialized

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[12] _____, "Governor Issues Reorganization Order," Michigan Department of Mental Health 'Link', Volume 5, Number 4, November 15, 1973, p. 3.

[13] Ibid., p. 3.

consultants in the areas of Nursing, Psychology, Social Work and Personnel as well as a sub-dividing of the Department into sections concerned with the institutions, the community clinics, mental health education and research. Eliminated was the assignment of a specific individual from the Advisory Council to be a periodic visitor to each of the institutions.

Although established in 1938, the full impact of the Civil Service Commission was not felt until after the war years. The State Legislature authorized the Commission to classify all positions in State service, fix the rates of compensation, make rules and regulations covering all personnel transactions and regulate all conditions of employment in the classified service.

The Mental Retardation Hospital Improvement project grant program was begun in 1964. It was designed to assist state institutions for the mentally retarded to improve their care, treatment and rehabilitative service. The maximum amount of support, including direct and indirect costs, that an institution could receive for any one budget year was $100,000.00. An analyses of the projects showed a major focus was placed on demonstration projects for the more severely retarded and dependent residents in the area of self-care training using operant conditioning methods.[14] For the first time, institutional personnel were challenged to develop innovative methods of better caring for their resident populations with a realistic possibility of having them funded.

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[14] _____, Mental Retardation Activities of the U.S. Department of Health, Education and Welfare, Washington, D. C.: U.S. Government Printing Office, 1969, pp. 49-50.

A journal article by Ellis,[15] served as a stimulus for many projects in Michigan. He proposed a toilet training program for the severely retarded using operant conditioning techniques. In addition to outlining a theoretical behavioral modification format to be used he asserted that: "It is apparent only in very unusual instances does biological accident reduce the human organism to a point below potentiality for learning. The writer has definitive evidence that some patients at the idiocy level who show little adaptive behavior are capable of learning."[16] It was necessary to make analyses of behavior such as eating, dressing and other self-help habits and to develop methods of teaching them to the severely retarded. 'These problems should be of central concern to behavioral science and should be termed 'hopeless' only after devoted attempts to alleviate them have failed. The present Zeitgeist provides a 'mental tester' role for the psychologist. Only when the psychologist puts aside his Binet kit and attacks problems such as this, as a behavioral engineer, will he come to grips with the central issue in mental deficiency."[17]

Initial Hospital Improvement Programs demonstrated that Ellis was correct, that severe mental retardates could be habit-trained. The President's Committee on Mental Retardation, in 1968, recommended that the Hospital Improvement Program having "elicited imaginative new

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[15]Ellis, Norman R., "Toilet Training the Severely Defective Patient: An S-R Reinforcement Analysis," American Journal of Mental Deficiency, Volume 68, Number 1, July 1963, pp. 98-103.

[16]Ibid., p. 103.

[17]Ibid., p. 103.

approaches to delivering residential care in state institutions"[18] be expanded to effect major change by greatly increasing funds with particular effort being made to meet the needs of the severely and profoundly retarded.

Behavioral modification projects brought psychologists and others into the mainstream of the resident care program in Michigan institutions for the retarded and began to bring about a change from almost total medical-nursing care orientation to a multidisciplinary approach in meeting the needs of the institutions' populations. The most tangible evidence of the evolution in resident care concepts is demonstrated by the action of the Michigan Legislature in passing Public Act 321 of 1969. This statute states that the Director of the Department of Mental Health "shall appoint a superintendent for each state home and training school who shall have such professional qualifications and experience as established by the director."[19] Prior to this legislative action only physicians, licensed to practice medicine in the State of Michigan were eligible for appointment as medical superintendents.

A national planning committee on accreditation of residential centers for mentally retarded persons was organized in 1966 by the National Association of Retarded Children, the American Association on Mental Deficiency, the American Psychiatric Association, the Council for Exceptional Children, the United Cerebral Palsy Association and the American Medical Association. In 1969 the five sponsoring agencies

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18 _____, M. R. 68, The Edge of Change, op. cit., p. 13.

19 _____, State of Michigan Mental Health Statutes, Lansing, Michigan: Legislative Service Bureau, 1969, p. 8.

formed the Accreditation Council for Facilities for the Mentally Retarded in order to establish a national, voluntary program of accreditation to improve the level of service for all mentally retarded persons.[20] The standards are intended to be applicable to all twenty-four hour programming institutions establishing needed levels of care necessary to provide each resident with the services which will enable him to attain maximum physical, intellectual, emotional and social development. Here in Michigan the State Association for Retarded Children has gone on record as being in favor of the state institutions being required to meet this standard and gain accreditation.

During this period the institutional populations have undergone a radical change. At the present time there is an almost total absence of the educable and trainable. A recent survey indicated that there were only a few mongoloid children under ten years of age at any of the state facilities. Fifteen years ago this diagnostic group made up twenty-five per cent of the population in that age grouping. Indications are that the institutional populations of the next era will be made up of severe and profound levels of retardation and severely multi-handicapped individuals.

TRAINING OF ATTENDANTS--In 1945, at the end of World War II, inservice training for attendant-nurses in the institutions under the newly organized Michigan Department of Mental Health was at an all time low. This depressed level of training was due primarily to the critical shortage of personnel that prevailed in all institutions

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[20] _____, A Development Model for Residential Services, Arlington, Texas: National Association for Retarded Children, 1972, p. 9.

during the war years due to national mobilization for duty with the armed services and maximum production in industry. As a result of insufficient numbers of personnel the attendant-nurse could not be freed from resident care duties to attend training and professional persons did not have time available to conduct training sessions.

Charles A. Zeller, M.D. was the first Director of the Department of Mental Health and Irene C. Walsh, R.N. was the first Nurse Consultant. Miss Walsh's duties were to organize and develop the psychiatric nursing affiliations in the mental hospitals for the collegiate and general hospital schools of nursing and develop the inservice training programs for attendant-nurses in the mental hospitals, the state home and training schools and the state hospital for epileptics.

First priority was given to the affiliate nurse programs and by 1953 all student nurses in Michigan were receiving a twelve week affiliation in psychiatric nursing. The only expansion of the program needed was to establish a site in the upper peninsula because student nurses from that area had to travel to the lower peninsula or out of state for training. The total student nurse enrollment during that year in the mental hospitals of Michigan was eight hundred and fifty.[21]

In 1953, there was no requirement for employment in the state for the attendant-nurse beyond passing a civil service examination. Each hospital and state home conducted a training program for attendant-nurses. The programs ranged in length from eighty to one hundred and thirty hours and were usually given over a three to four month period.

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[21] _____, Mental Health Research and Training in Michigan, A Survey of Facilities and Programs, Lansing, Michigan: Michigan Department of Mental Health, 1954, pp. 23-25.

"In some instances, the training programs began at the time of employment or after a brief orientation period. In the large percentage of cases, the program of training was given to the employees as soon as feasible and this might be from six months to two years after employment. In any event, all newly employed attendant-nurses received a basic orientation which ranged from sixteen to forty hours in length."[22] At that time, approximately five to six hundred attendant-nurses completed the training program annually. The Department of Mental Health report stated that the institutions could increase their inservice training activities "if instructor staff could be added and if time for training was allowed in the staffing for service."[23] It was estimated that at the time of the report a minimum of sixty per cent of the 5,728 attendant-nurses had completed the required attendant-nurse training program.

In conclusion the Department of Mental Health Survey of Training recommended that: "(1) Attendant-Nurse training should be reviewed with two factors in mind. The first factor was an evaluation of the method of training, and the second factor was the evaluation of course content to more factually determine whether or not the programs best prepared the attendant-nurse for the service required. (2) Additional instructor staff be added to the attendant-nurse training program in order to provide a more intensive inservice training program."[24]

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[22]Ibid., p. 28

[23]Ibid., p. 28.

[24]Ibid., p. 43.

During the first decade of the Michigan Department of Mental Health, although having "the prime responsibility for agency inservice training,"[25] did not demonstrate any significant advancement in the level of training of the attendant-nurse. Although the Department's Survey of Training indicated a lack of sufficient instructors as one of the factors that impeded progress, the second, namely the inability to have attendant-nurses available for training was, no doubt, a greater impedediment. In prior periods, all personnel attended training sessions as a part of their work day regardless of what time classes were held or how many hours they had worked. By 1945 the eight hour work day was in effect for all workers and that included time spent in training. Thus, with a limited number of personnel available for resident care, a limitation was placed on the number of attendant-nurses available for training.

Training curricula content and its applicability to the work at hand was also mentioned in the survey conducted by the Department. Analysis of the curricula being used at the time indicated that great emphasis was being placed upon subjects such as bed making and other basic nursing procedures and little or no time was devoted to the care of the mentally retarded or the mentally ill. Such a situation is readily understandable when consideration is given to fact that there were only thirty-five registered nurses employed in the entire Department of Mental Health in 1953 and the best trained were assigned to either the positions of Directors of Nursing or instructors for the psychiatric nursing affiliation programs. Registered nurses assigned

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[25] _____, Rules of the Civil Service Commission, Lansing, Michigan: Michigan Civil Service Commission, 1969, p. 39.

to attendant-nurse training, for the most part, had little or no training or experience in the care of the mentally retarded or the mentally ill. Method of instruction was basically the lecture with a minimal amount of demonstration.

Although the Department of Mental Health was apparently reasonably well satisfied with the training of attendant-nurses such was not the case with the recipients of the training. On August 17, 1954 a group of attendant-nurses from thirteen of the state institutions met at the Pontiac State Hospital to formally organize the Psychiatric Attendant-Nurse Association of Michigan. Discontent with the training they were receiving to assist them to better care for the mentally ill and mentally retarded in their charge they set out to obtain better training and official recognition. By March of 1955, the organization had more than nine hundred members.

A vigorous campaign was instituted by the Psychiatric Attendant-Nurse Association of Michigan to further increase its membership and to gain licensure under the Nurse Practice Act of Michigan. The groups' efforts were successful and on April 18, 1957 the Michigan Legislature passed Public Act 289 which established a fourth category of nurses, namely, the Licensed Psychiatric Attendant-Nurse which is defined by the Michigan Board of Nursing as meaning "the performance for compensation of acts in the care of the mentally ill and mentally handicapped, or for the maintenance of the health or the prevention of illness of others, performed in accordance with education and preparation which has provided the practitioner with a lesser degree of specialized skill, knowledge, education or training than that required to practice as a registered nurse. A licensed psychiatric

attendant-nurse shall perform such acts only under the direction of a registered nurse or licensed physician or dentist"[26] The new law also provided for the appointment to the Michigan Board of Nursing three Licensed Psychiatric Attendant-Nurses who were to serve "as members of the board only in relation to and for the purpose of administering the provisions of the act which related to psychiatric attendant nursing."[27] Public Act 289 required the Board of Nursing to make rules and regulations for the examination, regulation, licensing and registration of licensed psychiatric attendant-nurses and to define minimum curricula and provide for accreditation of schools and programs leading to their licensure.

In 1957 change in the Michigan Nurse Practice Act made provisions for waiving or "grand-fathering" in those who had previously practiced lawfully and reputably as psychiatric attendant-nurses. Individuals who had worked as attendant-nurses for five years or more during the ten years prior to July 1, 1958 and persons who had an inservice training course of one hundred and fifty hours and worked as an attendant-nurse for two or more years during the five years prior to July 1, 1958 were eligible to write the qualifying examination until July 1, 1960, provided they were of good moral character, had an eighth grade education and could produce verification of such practice by affidavits from one licensed physician or one registered nurse.

Many attendant-nurses availed themselves of the opportunity to gain licensure by the waiver clause as is indicated by the fact that

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[26] _____, Michigan Statute and General Rules Relating to the Practice of Nursing, Lansing, Michigan: Department of Licensing and Regulations, 1967, p. 2

[27] Ibid., p. 4.

in 1963 the Mt. Pleasant State Home and Training School had two hundred and thirty Licensed Psychiatric Attendant-Nurses and only two of that number had become eligible for licensure by attendance at a school accredited and approved by the Board of Nursing. They had attended the Northern Michigan College School of Practical Nursing which in 1960, with the approval of the Board of Nursing, had added a twelve week psychiatric affiliation at the Newberry State Hospital to their regular curriculum and thereby made their graduates eligible to take both the practical nurse and psychiatric attendant-nurse examinations.

The program at Northern Michigan College lasted only the one year and Pine Rest Sanitorium, a psychiatric hospital with a unit for the mentally retarded, located in Grand Rapids, and operated by the Christian Reform Church, was the only institution in the state to gain approval and accreditation from the Michigan Board of Nursing for a school of psychiatric attendant nursing.

Attempts within the institutions of the Michigan Department of Mental Health to establish training for attendant-nurses which would enable them to be eligible to take the licensure examination failed despite the fact that a Curriculum Guide for Inservice Training of Attendant-Nurses was developed by the Inservice Instructors and had the support and approval of the Department's Director. (SEE APPENDIX G.)

The Curriculum Guide consisted of an eighty hour Orientation Section, the two sections titled Fundamentals of General Nursing and Fundamentals of Psychiatric Nursing, each of two hundred and forty hours duration. Specific recommendations for implementation included establishing training wards and assigning the employees in training to

the education department during the training period. Although it was intended that all institutions in the Department of Mental Health follow the guide there was ample opportunity to vary the emphasis of the curriculum or alter the number of hours devoted to a particular subject area depending upon the training needs of the specific institution or sub-section of it. In the preparation of the guide the Suggested Curriculum for Inservice Training of Psychiatric Aides, prepared by the Michigan League for Nursing's Sub-Committee for Practical Nurse and Psychiatric Aide Education was utilized because the curriculum was used by the Michigan Board of Nursing as the standard for accrediting nursing programs preparing students for licensure.

The failure of either inservice or pre-service training programs to develop was due in part to the fact that the Michigan Civil Service Commission did not recognize the licensed psychiatric attendant-nurse by establishing a position classification for the group that was at a pay level above that of the untrained or partially trained attendant-nurse. Neither did any institution in the Department of Mental Health ever implement the level of training recommended in the Curriculum Guide for Inservice Training of Attendant-Nurses. There were several reasons for the failure, amongst them being a continually decreasing interest on the part of the Department of Mental Health administrators and many of the Medical Superintendents.

In 1967, a letter to the Superintendents of the Michigan institutions for the mentally retarded stated that: "As our institutions move toward specific defined program areas which reflect actual program content and activities, there is a commonly recognized need to provide

inservice training for the clinical program staff personnel (program aide) for development of those understandings, attitudes and behaviors necessary to promote effective programming and care of the mentally retarded. Specific inservice training is needed for program staff personnel within each clinical program. Our present State Curriculum Guide for Inservice Training of Attendant-Nurses which has been used in the past as a base for training does not suffice to meet present needs."[28] The letter further announced that the program consultants of the Department of Mental Health in the areas of nursing, special education, psychology, social work and activity therapies had started to develop a curriculum guide for inservice training of one of the program areas into which the retarded institutions had been divided. The ultimate results of this endeavor was the completion of a curriculum for one program when, due to the untimely death of Dr. Deiter, the project was not completed. The curriculum developed for the Growth and Development program staff placed much more emphasis upon the retarded youngster as a living, growing, learning individual and contained a specific unit on behavioral modification.

In 1968 the Michigan Civil Service Commission announced an additional classification level with an increase in wages for attendant-nurses. It was described as a merit promotion for those who had become skilled at their work. The objective criterion used to make the determination as to whom should be promoted was whether or not the individual had completed one hundred and fifty hours or more of

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[28]Letter from John B. Deiter, Ph.D., Assistant Director of Michigan Department of Mental Health for Research, Planning and Development and Evelyn Provitt, R.N., Associate Nursing Consultant, April 20, 1967.

approved inservice training. At the Mt. Pleasant State Home and Training School, a survey of the hours of inservice training attained by each attendant-nurse revealed that of three hundred and eighty-nine employed, two hundred and fourteen had sufficient inservice training hours to be eligible for a raise in classification level and a pay increase. Of this total, ninety-two were Licensed Psychiatric Attendant-Nurses. As a result of the Civil Service ruling an intensified inservice training was instituted.

A 1972 survey of the curricula presently being followed in the inservice training programs for attendant-nurses in Michigan's institutions for the mentally retarded reveals that very little change has occurred during the past decade. The most significant difference is in the area of curriculum content with units of study such as Individualized Resident Programming, Human Growth and Development, Behavioral Management, Behavioral Modification, Nursing Supervision and Management and Fundamentals of Supervision appearing for the first time. Also there is an over-all decrease in the number of training hours being allocated to the Fundamentals of Nursing.

The amount of time being devoted to the training of the attendant-nurse has increased with the latest report showing that the several training programs range from one hundred and twenty hours to two hundred and forty hours. The average number of hours utilized for training in the reporting institutions was one hundred and ninety hours.

Although the method of instruction has remained the same, that is, mostly lectures except for nursing demonstrations followed by return demonstrations there is a great difference in the disciplinary

background of the instructors, with physicians, psychologists, special educators, and many others participating along with nurses. In line with this multidisciplinary approach to instruction is a noted change in the reference and resource material being used.

CHAPTER VI

SUMMARY AND IMPLICATIONS

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SUMMARY AND IMPLICATIONS

Attendant-Nurse training in Michigan institutions for the mentally retarded has made little progress in the seventy-eight years since the Home for the Feebleminded and Epileptic opened at Lapeer. Present day training, both in content and methodology, are totally inadequate to meet the needs of retarded institutions that have evolved from the expected specialized training sites as envisioned by Samuel Gridley Howe, through the dismal period of custodial care to the threshold of the implementation of dynamic developmental programs that have expectations of providing the residents with an opportunity to grow and develop to the maximum of their potential.

Through the entire time span institutions for the retarded have existed, administrators, parents, governmental officials and innumerable others have extolled the work of the Attendant-Nurse, given recognition to the important role they play in the life of the institutionalized retardates and acknowledged that they should have better training. However, despite the many accolades bestowed upon Attendant-Nurses very little effort has ever been made to elevate their level of training.

Changes in curriculum content have been reflective mostly of the changes in personnel who have been responsible for the training of the Attendant-Nurse. Initially, physicians served as instructors and

their lectures were modeled on the medical courses in which they had participated. Far too many times, the lectures and clinical presentations were complex and technically beyond the understanding level of the Attendant-Nurse. With the advent of the nursing instructor, content and method of instruction became nursing oriented. General nursing subjects with demonstrations, return demonstrations and supervised practice became the predominant feature of the inservice training. The level of instruction, although less complex than that of the physician, continued to be at a high academic level. In recent years, other professional groups, particularly those oriented in the behavioral sciences, have played an increasingly important role in the training of Attendant-Nurses. They, like the physician and nurse, have presented their parts of the training sessions in complex terminology. Throughout the entire time Attendant-Nurses have participated in training programs, the instructors have expected the trainees to adapt to their level of academic attainment rather than making an effort to transpose their information to a level of instruction more easy for the average Attendant-Nurse to assimulate.

Conditions of employment have had an impact upon the success or failure of the inservice training of Attendant-Nurses. At the time the Lapeer institution was opened the rules and regulations stated that the institution contracted for the whole time of the employee which enabled the administration to hold classes in the evening after the residents had been put to bed. Even when the State Hospital Commission reduced the daily hours of duty to twelve and later to eight hours daily training classes continued to be held in off duty time. However, the Civil Service Commission ruled that all inservice training was to

be considered a part of the eight hour work day. This rule made it necessary to limit the number of Attendant-Nurses available for participation in training sessions because they had to be taken from resident care activities that were already understaffed. Unavailability of personnel to participate in training because they were needed to care for the retardates was as important determent as was the lack of capable instructors.

During the early days of Michigan's first institution for the retarded, its level of Attendant-Nurse training was comparable to that which was being conducted in both general and mental hospitals. However, in 1909 with the passage of Michigan's Nurse Practice Act, the Michigan Home for the Feebleminded and Epileptic failed to conform to the established standards set up for nursing schools. The probability is that, had a training school for nurses been begun it would have suffered the same fate as the nursing schools at Kalamazoo, Pontiac and Traverse City. However, in 1957, the failure of the Michigan Department of Mental Health and the Michigan Civil Service Commission to provide an appropriate classification for the Licensed Psychiatric Attendant-Nurse at a pay level above that of the Attendant-Nurse probably did more to provide for the doom of the efforts of the Psychiatric Nurse Association of Michigan to acquire recognition and status than any other one factor.

After more than seventy-five years of attempts to institute and maintain meaningful inservice training programs for Attendant-Nurses in the Michigan institutions for the mentally retarded it seems reasonable to assert that the foregoing survey indicates that the attempts have to be considered failures. However, recent events in

the area of the training of Attendant-Nurses gives indications that a new era is within the realm of probability just as it now appears that a new and more promising era has begun for the mentally retarded.

After several years of procrastination Michigan, in 1971, decided to participate in the Federal Government Medicaid Program wherein the State could obtain specified amounts of Federal monies for the patients in institutions for the mentally retarded that required a skilled level of nursing care. In order to participate in the Medicaid Program and receive reimbursement the State was required to meet certain standards amongst which was the requirement of having one Licensed Nurse for every seven Attendant-Nurses. Not having sufficient Registered Nurses and Practical Nurses to meet this requirement it was necessary to count the previously rejected Licensed Psychiatric Attendant-Nurses to meet the stipulated standards. As a result of this situation the Psychiatric Attendant-Nurse Association, which had been in a state of limbo during the latter part of the 1960's, again became active. They again sought recognition for their licensed status and in June of 1973 the Department of Mental Health in conjunction with the Civil Service Commission came forth with specifications for a career ladder for personnel in the mental health field which gave Licensed Psychiatric Attendant-Nurses recognition at a classification level equal to the Licensed Practical Nurse.

Concurrent with the above and as a result of the impetus provided by the availability of Vocational Education funds from the Federal Government several Michigan community colleges, as early as 1968, became interested in the training of individuals, at a technical level, for careers in the mental health field. This interest has

developed into actual programs at Wayne County Community College, Mid-Michigan Community College, Oakland Community College and Schoolcraft College for the granting of an Associate of Art degree in the field of mental health. The Mid-Michigan Community College describes its program as follows: "The Mental Health Technician Program is designed to prepare graduates for beginning positions in the semi-professional occupations for employment in mental health clinics, general hospitals, mental institutions and training schools for the retarded and emotionally disturbed."[1]

Two recent studies have, for the first time, realistically focused on the performance and function of the Attendant-Nurse. McBride demonstrated that institutional administrators reinforced the traditional custodial care role of the Attendant-Nurse rather than rewarding them for their contributions to the training of the mental retardates in their care.[2] Rowland demonstrated that Attendant-Nurses, with appropriate assistance, could effectively supervise higher functioning institutionalized retardates as they aided lower functioning retardates in the acquisition of language.[3]

Despite the fact that inservice training of Attendant-Nurses in Michigan has proven to be less than successful there is a hopeful

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[1] _____, Mid-Michigan Community College Catalog, 1972-74, Traverse City: Village Press, Inc., 1972, p. 46.

[2] McBride, Hugh J., "The Differential Effectiveness of Two Methods of Training Institutional Attendants in the Techniques of Behavior Modification," (unpublished Ph.D. thesis, Michigan State University, 1972).

[3] Rowland, Martha E. S., "A Study of the Use of Higher Functioning Retardates as Language Acquisition Trainers of Lower Functioning Retardates in Attendant Supervised Training Sessions in Institutional Wards," (unpublished Ph.D. dissertation, Michigan State University, 1973).

outlook for the future. The past several years has seen the beginning of community college programs for the training of Mental Health Technicians who will have the basic preparation to function in the role now assigned to the Attendant-Nurse and be eligible to the licensure examination to become Licensed Psychiatric Attendant-Nurses. However, in order to attract the graduates of the community college programs to basic level institutional positions they must be given recognition for their training by establishing appropriate classifications and salaries. Additionally, institutional administrators need to make greater efforts to avert actions that reinforce the custodial orientation of the Attendant-Nurse and give support to their participation in training of the retarded residents. Also, of great importance is the need for meaningful research that will demonstrate the ways in which the Attendant-Nurse can become maximumally effective in the care, training and rehabilitation of the populations of retarded institutions.

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APPENDICES

APPENDIX A

Rules and Regulations

...of the...

MICHIGAN HOME

...for the...

FEEBLE-MINDED AND EPILEPTIC

Lapeer, Mich.

..1897..

Lapeer Press Print.

RULES AND REGULATIONS

The Superintendent

The Superintendent being by law the chief executive officer of the Home, is the head of the establishment. He shall have the general superintendency of the entire institution, and the direction and control of all persons employed therein.

He shall superintend the preparing of bills of fare of the meals served to the children and household.

He shall from time to time confer with the Steward and Matron regarding the affairs of the institution, and furnish them with lists of children whom he considers capable of working in their respective departments.

He shall inquire into the condition of the inmates daily, or as much oftener as may be necessary, and shall direct such medical, moral and physical treatment as may be best adapted to their condition.

He shall keep a record of the name, age, sex, place of nativity, and residence, of each inmate, also as far as can be ascertained, the date and history, and probable cause of his or her mental condition; the time when received and when removed, and from what cause; together with any results or statistics likely to promote the interests of science and humanity.

He shall keep a record of the names and residences of all persons employed in the institution, with the time and terms of their respective engagements, and if discharged, the date and cause.

He shall, if requested, at each visit of the Board of Control exhibit the records of the institution, and inform them minutely of its affairs, making such suggestions as he may think the interests of the institution may require. He shall prepare for the Board of Control an annual report, in which he shall show the history, progress and condition of the Home, and the success of the attempts to educate and improve the Feeble-minded and Epileptic. He shall receive and answer all communications relating to the concerns of the institution and keep a record of all correspondence.

The Steward

The Steward shall have the superintendence of the farms, stables, barns, gardens and grounds, together with the furniture, horses and stock, and all supplies of clothing and food for the institution, under the direction of the Superintendent. He shall have charge of the store-rooms, under the general direction of the Superintendent, and be responsible for the safe-keeping and economical distribution of stores.

He shall issue no supplies except on requisitions approved in writing by the Superintendent. He shall keep accounts of the house expenses, of the income derived from the inmates for their maintenance and from all other sources separately, which accounts, with other records of the institution, shall at all times be open for examination by the Board of Control.

He shall see that all of the departments under his supervision are kept clean and in good order, and that all employees perform their duties faithfully, reporting to the Superintendent any instance of neglect or misconduct.

During the temporary absence of the Superintendent, he shall, so

far as practicable, have control of the affairs at the Home, unless the Board shall direct otherwise.

All leaves of absence of outside employees, granted by him should be reported to the Superintendent. He shall receive and answer all communications relating to the business affairs of the institution entrusted to him, and shall keep a record of such correspondence.

The Matron

It shall be the duty of the Matron to act with the Superintendent, be subject to his authority, direction and advice, and maintain good discipline and economy. It shall be her duty to exercise a motherly supervision of the children. She shall, under the general direction of the Superintendent, have charge of the entire domestic arrangements of the institution, and shall see that all departments are kept clean and in good order.

She shall have the supervision of the cooking for the inmates and household, and of the regular distribution of food to the several dining rooms, at such hours as the Superintendent shall direct; also of the sewing and mending rooms and laundry, and all employed therein.

She shall, unless the Superintendent for sufficient reasons otherwise orders, have the right of visitation of the hospital at all times.

She shall furnish employment for such children as the Superintendent considers capable of working in the departments. She shall assign the duties of the Assistant Matrons, who shall always be under her direction.

Assistant Matrons

The Assistant Matrons in charge of a particular building shall have entire charge of the domestic economy thereof, subject to the

direction and control of the Superintendent and the Matron.

Principal Teacher

The Principal Teacher shall from time to time classify those children whom the Superintendent considers capable of receiving instruction, and for that purpose she shall provide training, kindergarten and primary schools.

She shall assist in teaching, and perform such other appropriate duties as the Superintendent assigns to her. She shall, subject to the approval of the Superintendent, make such rules and regulations for the government of the schools, as shall best serve the interests of the same, and from time to time make such recommendations as may lead to improvement in her department. She shall present semi-annual reports of the condition of the schools, at the 1st of June, and 1st of December.

As to the mental condition of the children in the schools, she shall confer with the Superintendent and be guided by his advice. He shall, at her request, make the necessary examinations of the children as to their condition and ability to receive instruction.

Assistant Teachers

They shall be under the direction of the Principal Teacher, whose instructions they shall receive and carry out in all things pertaining to the teaching of the children, and shall discharge such other duties as the Superintendent may assign them.

Attendants

The duties devolving upon Attendants are arduous and responsible, requiring great self-denial, sovere schooling of temper and disposition; and all accepting such positions are expected to perform their

duties cheerfully, zealously, and promptly, and in no case shall they be allowed to punish inmates, but must report any misconduct to the Superintendent. Under all circumstances the law of kindness must be the governing one; other qualifications will be of little value, if the disposition to carry out this law is wanting.

The Attendants have charge of the children out of school hours, and when not transferred to some special department, each Attendant having the care of a group, over which he or she is to preside; teaching, guiding and directing with patience. They shall see that the children rise at the designated hour, and are properly washed and dressed.

The more advanced children may assist in this work, but the Attendant must superintend all such help.

Attendants shall preside at meal hours, watch and direct their play time, see that they are prompt in responding to school and work hours, or such other duties as may be required. In the dining room they must maintain good order, instructing the children in proper modes of eating, drinking and sitting, for at no other time of the day can the children receive such important lessons in order and propriety. Talking is not to be allowed, and the children must be kept in their seats at the table for at least one half hour.

After meals, and on arising and going to bed, (sometimes oftener), the Attendant of each group of children must take them to the water closets to prevent accidents to bedding and clothing. Untidy children must be kept clean and dry at all times, and all soiled clothing be sent at once to the laundry.

There are times when the charge of large groups of children is

thrown upon one or more detailed Attendants, and no ill-will or prejudice against each other must in such case affect any one in the care of children belonging to another. Attendants will be expected to be always neatly dressed in uniform when on duty.

They shall instruct the children to kneel at their bedside every night and morning to utter some simple prayer. Dormitory rules will be regulated by the Matron, and all needs of the children are to be referred to her. Attendants shall have one-half day off duty during the week, and part of Sunday.

The Engineer

The care and oversight of the engines, boilers, machinery, appliances for fire protection, pumping apparatus, heating and ventilation, tanks, sewers, steam cooking apparatus, laundry apparatus, water, steam and electric supplies, are committed to the Engineer.

He shall not permit anyone to enter the boiler, engine or machinery rooms, without an order from an officer, or upon a necessary errand. He is made responsible for the proper conduct, punctuality and fidelity of his assistants. He is expected to devote his whole time to the institution, and to regulate his hours according to the necessity of the case.

He shall keep an accurate account of the time and service of those who work under his direction, and report monthly in detail the object to which all labor has been applied.

Night Watchman

The Watchman shall call at the office every evening to receive any particular orders for the night. His hours of duty will begin at seven o'clock p.m., continuing until seven o'clock a.m., the following

day. During the night he must be faithful and vigilant, making as little noise as possible. He must be especially careful to guard against danger from fire, the least suspicion of which in any part of the institution should excite his immediate attention. He shall visit the lower halls of all buildings as often as required during the night, shall attend to the fires in the kitchen, etc., as directed by the Superintendent or his representative.

It is the duty of the Watchman to guard during the night against violations of rules of the institution, and report such violations to the Superintendent in the morning. He must see that no unnecessary lights are burning, and report employees who leave their rooms without turning out their lights. In fact, attend to all duties at night for the safe care of the inmates and employees.

The Farmer

The special care of the farm, garden, barns, farm teams etc., utensils, stock including hogs, cows and poultry, is assigned to the Farmer, under the general supervision of the Steward.

He shall see that tools, harnesses, etc. are kept in good order and repair, and that nothing is lost. He shall also keep an accurate account of the time and service of those who work under his directions, and report monthly in detail the object to which all labor has been applied. He is required to devote his whole time to the service of the institution.

Neither he nor his assistants may absent themselves from duty without the knowledge of the Steward.

No institution property of any kind is to be taken from the farm or to be used for private purposes except by special arrangement in

each case. If additional farm labor is required, the Farmer shall report to the Steward for authority to employ the same.

General Rules

1st. Do not gossip. The doings and mishaps of the Home must be kept as private as in any well ordered home. The affairs of the institution or its officers are not to be discussed by employees either in the institution or outside.

This rule must not be violated under pain of dismissal.

2nd. It must be distinctly understood that the Home contracts for the whole time of all employees, and that they are not to leave the premises, or their assigned duties, nor to engage in work of their own, without express permission from the proper authority. They must expect an unceasing observation of the manner of performing their respective duties, and kindly receive and promptly heed every suggestion in regard to deficiencies or improvements.

3rd. All employees are expected to perform with cheerfulness and to the best of their ability, all duties which may be assigned them; and at all times or in all places to do what they can to promote the comfort and happiness of the children and the prosperity of the institution.

They are expected to feel a sufficient personal interest in the welfare of the Home and its inmates, to be ready and willing to respond to a call from the Superintendent or his representative, to any duty which an emergency might necessitate.

4th. They are expected to fulfill their engagements scrupulously as to time of service; and no one shall discontinue service without giving four weeks notice to Superintendent or Steward. When the

institution wishes to dispense with the services of any one, the same notice will be given, except in the case of persons discharged for violation of rules, or improper conduct.

5th. It is distinctly and positively enjoined that the rule of government is that of kindness, and no severity towards the children will be tolerated. Corporal punishment is never to be inflicted, except by the Superintendent, or in his absence, his representative. All tantalizing, striking, etc., are strictly forbidden.

6th. Employees must treat the children, each other, and any one having business at the Home, with kindness and courtesy, as in order to teach the children to be kind, obliging and respectful, they must be so to each other. Cheerfulness is always to be desired, but levity and boisterous conduct are forbidden. Especially avoid making any noise that may disturb the children after they have retired.

7th. Refrain from all recital of grievances, and conversation of an objectionable nature, at the table, at work, or before the children. If you cannot, as a rule, be cheerfully prompt and responsive to reasonable demands made upon you, forbearing with the children and each other, you are not fitted for a position in this institution. Guard well your language and temper; swearing will not be permitted. By each one attending strictly to his or her own affairs, much trouble will be avoided.

8th. While it is desired to give as much relaxation as possible to those who perform their arduous duties well and faithfully, yet when the absence of any one connected with the institution is likely prejudicial to its interests, ALL will be expected to remain on duty.

9th. Every employee is responsible for the children under his

or her care, and is expected to be able at any moment, to say where each child is, or into whose charge he or she has been given. No child is to be taken from the cottages for work or for any purpose or by any one without mentioning the fact to the attendant in charge. No child is to do sewing or other work for the private benefit of employees, unless by special permission from the proper authority; and the children are not to go to the rooms of employees without permission.

10th. Employees must not write to friends or relatives of the children unless authorized to do so by the Superintendent, and all letters to be submitted to him. Neither must they accept any fee or reward from friends of the children.

11th. The children must be protected from the idle curiosity of visitors, and do not report their names or pecularities in the presence of strangers.

12th. All employees will be held personally responsible for the cleanliness, good order and general appearance of their respective apartments, and must be prepared at all times for their inspection by the Superintendent, Matron or detailed officer.

13th. Male employees are forbidden to enter the buildings occupied by females without permission from the Superintendent or Matron. All company to be entertained in the public sitting room or other place designated by the Matron.

14th. Do not loiter in places where you are not regularly employed; if you have business to transact, attend to it promptly and return then to your own department.

15th. Employees when at leisure must not visit other employees who are on duty.

16th. Do not throw anything from the windows, or about the grounds, and do not allow it to be done.

17th. Take no furniture or any other institution property from one room to another without permission from the proper authority.

18th. Do not invite your friends to take a meal with you, without previous permission from the Superintendent, or his representative. The Matron to be always notified of any guests in the institution.

19th. All persons employed in any capacity upon the premises, whose duties are not specially defined here, will nevertheless be expected to conform to the general spirit of the rules in every particular.

20th. When going off duty, employees must leave their keys in the office. The hour for closing the institution for the night is 10:30 o'clock, at which time the doors will be locked.

Visitors

The institution will be open to visitors on Wednesdays from two to four p.m. Friends of the employees are requested, as far as possible, to confine their visits to these hours. Sunday shall be observed as a day of rest and quiet. No visitors to be admitted, without special permission.

Vacations

At the expiration of a full year, a vacation of two weeks is allowed employees who work by the month, except those whose positions cannot be filled by substitutes. Such employees may have time off when their duties will permit. Teachers will be allowed one month vacation (with salary) during the summer school closing.

Rules for Bathing

1. Every inmate is to be bathed as soon as possible, after admission, and the hair combed with a fine comb.

2. Inmates shall be bathed at least once a week, at such times as designated by the proper officer, and as much oftener as may be necessary to keep the body clean.

3. In preparing a bath, the cold water is always to be turned on first, and then the temperature of water raised to a point not above 98, and tested before the inmate enters the tub or shower.

4. Before the child enters the bath, the temperature is to be ascertained and is not to be less than 88 degrees, nor above 98 degrees. Older children may assist in bathing the younger and more helpless ones, but never except when an attendant is present.

5. The bath tub is to be emptied and cleaned after each child. Two children are never to occupy the bath at the same time.

6. The body of each child is to be carefully cleansed and thoroughly dried, after which the clothing is to be put on as soon as possible.

7. Any marks, bruises, sores, pain or evidence of disease of any kind, complained of by the child or noticed by the attendant, must be reported as soon as possible.

8. At least one hour must follow a meal, before bathing. After the bath the finger and toe nails are to be trimmed.

9. Shaving and hair cutting of older male inmates, to be done by male attendant at stated times.

APPENDIX B

THE PHYSICAL CARE OF CHILDREN

(A talk to Attendants.)

LOUISE PATTERSON, M.D.

VINELAND TRAINING SCHOOL BULLETIN

VOLUME V

October, 1908

Pages 12-14

THE PHYSICAL CARE OF CHILDREN

(A talk to Attendants.)

Louise Patterson, M.D.

You have probably heard it said of the feeble minded, that on their arrival in this world, they find an environment entirely unsuited to them. Allow me to carry that a step further, and say that the majority of children who are born find an environment and conditions not only unsuited to them, but absolutely injurious and detrimental to their existence. I have only to tell you that 50% of all children born die before they are 5 years old, and that 30% of those who die, die from indigestion in some form, to give you the idea of the scope of the lack of knowledge as to the physical care of the child.

It does seem to me as if those to whom some special glimmer of light comes through the darkness should "Cry aloud and spare not" that these little ones may be cared for by the most improved and rational methods. If we have been in the line of this light belt, let us "Let our light so shine" that the darkness may be dispelled.

This subject of physical care divides itself naturally into two headings.

1. The care during health.
2. The care during disease.

The first will be the principal topic of this talk.

The physical care of children during health is subdivided into

a. The Choice and Care of the child's home and diet.

b. The Care of the child's body.

In an institution it will be necessary, of course, to take the homes as you find them, and do the very best you can with respect to cleanliness, fresh air, sunshine, heat, etc. The subjects of sanitation and ventilation should be dealt with at some length, but just here let me tell you that scrupulous cleanliness in every respect is very necessary in the care of all. I cannot at present think of a much more dangerous thing than dust, just because it gets mixed up with the excreta from the body and is blown about. The careless child flops its duster here and there, scattering and not gathering up the little elements of danger. A sink that emits an odor, or a toilet that is stopped up is dangerous and needs reporting and rapid action. Fresh air is very necessary. We can live 40 to 60 days without food, 14 or more days without water, but we die in a few minutes if the whole supply of air is cut off. Nearly all of our cottages are ventilated when the fan is running and the register open.

Sunshine is God's disinfectant, and is necessary to the growth and development of children. A plant set back in the room will become white and sickly, spindly if you please. A child kept out of the fresh air and sunshine will grow white, weak and spindly. If you wish to keep your children well, keep them out all possible.

Heat is much more dangerous than cold. A temperature of 85 is more to be feared than a temperature of 60 or even lower, but the great danger lies in sudden variations of temperature, such as having a child in a day room with a temperature of 80 and taken to a dining-room where the temperature is 56 or 60. If the heat cannot be kept from 65 to 72, every effort should be put forth not to let it get above 70, or even to keep it lower. There should be a thermometer in every

day room, dormitory, dining-room, etc., and these should be consulted and an effort made to keep them as near right as possible. Heat is more dangerous than cold.

Now as to the care of the bodies. Allow me to remind you that you take the place of the parent to the most unfortunate class of children in the world. As you look at the helpless one, think "he is some mother's boy. I will do my best for her sake. She had no place to keep him." Little we know how many Gethsemenes have been gone through by the parents of these children! Little do we know of the heart-rending cries of the fathers and mothers as they give us the afflicted one, committing it to our tender care with a heartache that I hope we may never feel! Ah, my friends, when they come to us we must take up the threads of responsibility concerning the care of their bodies and weave a web of happiness, helpfulness, and love into their little darkened lives!

How does the mother heart care for them? She sees that they are properly clothed day and night. If it is too cold, she puts on an extra blanket or heavier underwear; she sees that the shoes and stockings are heavy enough and whole; she sees that the clothing is buttoned on properly, that the buttonholes are so they will hold the buttons, she sees that they have the proper amount of food at each meal, and is solicitous if they will not eat, taking them to the doctor; she sees that the skin is kept clean and in a healthy condition, also that the teeth are cleaned at least once a day, that each child has his own tooth brush; she sees that nature's wants are attended to, and at the first disturbance in that direction, she reports at once. She is very anxious that the child should have exercise in the fresh air. If a

child is restless at night and wakeful, but is not sick, I know of no better medicine easier to administer than a long walk in the air, a rapid walk, till the child gets comfortably tired. Sometimes a glass of hot water at bedtime will induce sleep.

The mother is very careful on wet days about the feet. Usually the head can be wet and there will be no trouble, but if the feet are wet, there will be danger. I believe it would be wise to report wet feet, and if found, to rub vigorously. It would only take a minute and might save a weeks work in case the child got pneumonia.

In case of a spasm, the child during the attack should be laid down and the clothing at the throat unfastened. Indeed, it is best not to have tight clothing on a child addicted to spasms. Sometimes it takes a couple of minutes before anyone can get there. It is also best to allow them to sleep for a time after a spasm.

When the children are outside, it is wise to play with them. It makes them happy, and makes better blood, muscle and bone. In fact, it makes the whole body better. The child that is sluggish should be encouraged to move at least, but not be dragged around because some serious injury might be done.

About the eyes, nose and ears, children need to be restrained from putting foreign substances into these places. And the ears, nose and eyes should be kept clean, and the doctor called if there is some foreign matter in them. As often as practical, the bodies should be looked at for boils or sores, and these reported.

Many of these children have a mania for eating trash. Try to restrain such. Leaves, limbs of trees, acorns, toad-stools, paste-board boxes, and corn husks are hard to be dealt with and will either kill or

cause serious danger to health.

Corns are the better for being filed down once a week at least, and the nails kept trimmed. Ingrowing nails are very obstinate, and if they get sore should be noticed by the doctor. Such nails are the better for being scraped thin on the centre of top, or cut with a nick in the centre. Broken shoes should receive attention at once, as there is great danger. Keep the feet warm if you would avoid trouble.

Try to make the child happy. Upon this depends so much. The food will digest better and more rapidly, the blood will circulate more freely, if the unfortunate one feels that at last he has found a home and a mother heart to whom he may go for guidance, or help in all his troubles.

APPENDIX C

C U R R I C U L U M

Recommended by

THE MICHIGAN STATE BOARD OF

REGISTRATION OF NURSES

to the

TRAINING SCHOOLS

in the

STATE OF MICHIGAN

THE MICHIGAN STATE BOARD OF

REGISTRATION OF NURSES

issues the following curriculum as a standard for the guidance of training schools for nurses, and the same shall be considered the minimum of instruction to be given to comply with the law.

November, 1910

CURRICULUM

The period of instruction in the training school shall be not less than two full years, and said two years to be devoted entirely to hospital training.

The Course will be divided as follows:

Probation: Two months. (The first two weeks of this time for preliminary work.) Junior term. Senior term.

Preliminary Work: Two weeks.

First Week: Talks on care of rooms; care of bathrooms; utensils and their uses; practical work in caring for pupils' rooms and bathrooms. Sweeping and dusting, one hour daily. Talks on hospital routine, rules and ethics of nursing, one hour daily. Talks on bed-making, demonstrations of same, one hour daily. Preparation of trays and serving of food, one hour daily. Talks on bathing, demonstrations on bathing, one hour daily. Talks on pulse, respiration and temperature, practice in taking same, one hour daily. Study hour, one hour daily. Recreation time, two hours daily.

Second Week: Care of patients' rooms, one hour daily. Care of linen and linen room, one hour daily. Serving trays and feeding helpless patients, one hour daily. Talks on simple disinfectants and their use, practical demonstration of the same, one hour daily. Bed-making with patients in bed, one hour daily. Study hour, one hour daily. Recreation time, two hours daily.

At the end of this two weeks, the probationers go to the wards and are required to continue this training by practical work. At the end of two months, if accepted they become pupil nurses and are given their uniforms. No probationer shall be allowed to catheterize patients, care for patients recovering from an anaesthetic, administer drugs or in any way care for critical cases.

Nursing: Practical work and instruction begin with the day of one's entrance into the school and are continued throughout the course. One rule that must always be adhered to is that every duty shall be made familar to the pupil and that the performance of it shall be under the supervision of the Superintendent of Nurses, her assistant, or a senior nurse, until such time as the pupil may consistently undertake the responsibility of it herself. Thus, by classes, demonstrations and bedside clinics, all the work and responsibilities are anticipated that later will be assigned the nurses in their regular duties.

PRACTICAL WORK FOR THE JUNIOR YEAR.

The following are some of the subjects demonstrated during the first year, many of them offering material for one or more lessons: household sanitation; personal hygiene; bed-making; general order of the ward; points in making patients comfortable; pulse, temperature and respiration; hydrotherapy, sponging, packs, hot and cold, tubbing, in bed and bedside; use and care of ice coil, ice cap, ice bag, hot water bottle, air cushion, rubber gloves; charting; care of the dead; gastric lavage; gavage; enemata; fomentations; stupes; handling of sterile supplies; giving of medicines; making solutions; giving hypodermics and care of instrument; counter irritants, poultices, plasters, cupping, use of iodine; positions and draping of patients for

examination; surgical cleanliness, disinfectants; catheterization; douches, vaginal vesical; preparation of patient for operation; care of patient after operation; care of dressing-room and its supplies; surgical preparation of supplies; of patient; fractures; bandaging.

LECTURE COURSE: JUNIOR YEAR.

Lectures in Hygiene and Sanitation, 6; Bacteriology, 4; Materia Medica, 8; Anatomy, 6; Physiology, 6; Urinalysis, 3; Dietetics, 4: (1) Foodstuffs and their classification, (2) Principles of Cooking, (3) Beverages: Milk, etc., (4) Serving of Food, Combinations of Food, and 12 lessons in practical demonstration in diet kitchen.

Written examinations to be held at the end of each course of lectures.

SENIOR YEAR.

Surgical Nursing and Gynaecology: Practical demonstration: Use of antiseptics; aseptic, disinfectants, germicides, deodorants; sterilization by heat and chemical agents; nurse's technic in preparing sterile dressings and utensils, in assisting at surgical dressings, and in preparing for and during operations; the preparation of the patient for the operation and after care; the preparation for gynaecological examinations and the positions for the same; the application of splints and extension.

Obsterical Nursing: Nurses should be required to care for at least 6 cases of confinement both during and following labor.

The practical lessons should include: the preparation of room and patient for normal labor; the preparation of patient for different positions for examination or delivery; after care and treatment; the

massage and treatment of the breast; the application of the breast binder.

Nursing of Infants: The practical lessons should include: Method of bathing; the baby's first bath; the special care of the baby's eyes, nose, mouth and genitals; the care of the skin; the preparation of the baby's food; artificial feeding; the care and handling of bottles, utensils, clothing, etc.

Bandaging: The practical lessons should include; bandages, use, material, methods of making, spiral, figure of eight, reverse, arm, elbow, shoulder spica, hand bandages, finger and thumb spica, foot and leg, head and eye bandages, binders of various kinds, plaster of Paris bandages, splints.

Methods of Instruction: The demonstrations and clinical teaching in the wards shall be given by the Superintendent of Nurses, her assistant or senior nurses. The classes should recite regularly and written quizzes should be required frequently. Occasional lectures on special subjects (like the eye, ear, nose and throat) should be given the entire class during the course.

LECTURE COURSE: SENIOR YEAR

Lectures in Surgery, 6; Gynaecology, 5; Obstetrics, 6; Medical Nursing, 6; Nursing Sick Children, 4; Infectious Diseases, 6; Nervous Diseases, 4; Anaesthetics, 2. Each lecture is to be preceded by a quiz of fifteen minutes.

Final examinations at close of school year.

The following are a few suggestions regulating the work of the Training Schools, which the Michigan Board of Registration of Nurses believes should be carried out by the hospitals.

(1) Special hospitals should affiliate with general hospitals, for the work which they are unable to give their pupils, in order to be recognized by this Board.

(2) All training schools should keep an accurate record of each pupil's qualification, class work, examinations and time spent in each service.

(3) Whenever practical, the lectures and classes should be held during the day, instead of evenings.

(4) In the two years' course, the class work should be not less than eight months in each year.

(5) Continued and special instruction should be given throughout the course in Dietetics, Hygiene, Obstetrics and the Nursing of Sick Children, as these subjects in the past have not been given sufficient attention.

(6) All hospitals maintaining training schools should employ a graduate nurse, who holds a diploma from a reputable training school (preferably a registered nurse) to teach and supervise all practical instruction.

List of Text Books Recommended for Use in the Training Schools for Nurses.

Anatomy and Physiology:—	Anatomy and Physiology.	Kimber.
	Anatomy for Nurses.	.Bundy.
	Anatomy and Physiology for Nurses	.Lewis.
Bacteriology:—	Bacteriology for Nurses	.McIsaac.
	Bacteriology in a Nutshell.	Reed.
Care of Infants and children:—	Care of the Baby.	Griffith.
Dietetics:—	Dietetics for Nurses.	Friedenwald and Ruhrah.
	Diet in Disease	Pattee.
	How to Cook for the Sick.	Sachse.
	Hand Book of Invalid Cooking.	Boland.
Ethics:—	Nursing Ethics.	Robb.
Gynaecology and Obstetrics:—	Obstetrics for Nurses	.DeLee.
	Obstetrics and Gynaecologic Nursing	.Davis.
Hygiene:—	Hygiene for Nurses.	.McIsaac.
	Personal Hygiene.	Pyle.
Materia Medica:—	Materia Medica for Nurses	Dock.
	Materia Medica for Nurses	Paul.
	Quiz Compends on Materia Medica	Potter.
Mental and Nervous Disease:—	Nursing the Insane.	Barrus.
	Psychology and Mental Diseases.	Burr.
Nursing:—	Primary Nursing Technique	.McIsaac.
	Practical Nursing	Maxwell and Pope.
	Nursing—Its Principles and Practice.	Robb.
	Clinical Studies for Nurses . . .	.Charlotte A. Aikens.
Surgery:—	A Nurse's Guide for the Operating Room.	Senn.
Urinalysis:—	Guide to Examination of Urine	.Tyson.
Dictionary:—	Medical Dictionary.	.Gould.

APPENDIX D

MICHIGAN BOARD OF REGISTRATION OF NURSES AND TRAINED ATTENDANTS

SCHOOLS FOR TRAINED ATTENDANTS

REQUIREMENTS AND COURSE OF INSTRUCTION

March 18, 1928

SCHOOLS FOR TRAINED ATTENDANTS

REQUIREMENTS

1. Schools for training of attendants may be established in a hospital or sanitarium having no training school for nurses.
   Schools for training of attendants must be inspected and approved by the Michigan Board before students are admitted.

2. The course of training shall not be less than nine months or more than one year; practical nursing experience to cover at least six months as required by law.

3. The school must be conducted by a registered nurse, who is qualified to teach the students elementary practical nursing procedures, preparation of diets for the sick, and to hold such class instruction as may be outlined by the Board.

4. Suitable room must be provided for classes and practical demonstrations.

5. A record must be kept by the School of each student's class and practical work as follows:

   (a) Name and address.
   (b) Date of entrance.
   (c) Age.
   (d) Preliminary education.
   (e) Physical condition.
   (f) Number of classes held weekly in each subject.
   (g) Number of hours given weekly to practical demonstrations of nursing methods.
   (h) Grades on each written examination.
   (i) Number of weeks in caring for patients in different services.
   (j) Grades on practical nursing performed in the demonstration room and in the sick room.

6. Time on regular duty should average about 54 hours weekly.

7. Sanitary and hygienic living accommodations must be provided for the students. This refers to sleeping hours, hot and cold water supply for bathing purposes and proper food.

8. Uniforms should be plain and should not duplicate uniforms of students in accredited training schools for nurses or include a nurse's cap.

9. It is the opinion of the Board that certificates of graduation issued to attendants should be uniform from all schools; to be worded similar to sample on last page of this leaflet. School pins are not a necessity as a requirement of the Board of Registration of Nurses and Trained Attendants.

REQUIREMENTS FOR ADMISSION TO A SCHOOL FOR TRAINED ATTENDANTS

(a) Age: 19 years and 3 months for a course of 9 months. 19 years for a course of 12 months. (Applicants will not be admitted to examination until 20 years of age.)

(b) Education: Eighth grade or equivalent. Applicants having two years high school or equivalent should be encouraged to enter a school for nurses.

(c) Moral and physical fitness.

MINIMUM COURSE OF INSTRUCTION FOR THE TRAINING OF ATTENDANTS

1. The course of instruction should cover the entire period of training which, according to law, may not be less than nine months; six months of which to be spent in the actual care of patients.

2. The following outline for classroom work in theory and practical demonstration will be considered the minimum requirement of the Board. It is the opinion of the Board that the course should be elementary and practical with emphasis on the latter. This outline may be altered by the Board at its discretion:

Practical nursing demonstrations	67 hrs.
Household and Personal Hygiene	15 hrs.
Elementary Anatomy and Physiology with emphasis on Physiology	15 hrs.
Diet for the sick and in health including class and practice cooking	30 hrs.
Ethical Standards	8 hrs.
Total	135 hrs.

The accompanying outlines must be covered fully.
The school may give additional hours on any subject as it desires.
The record of extra work must be kept on file.

BOOKS RECOMMENDED FOR CLASS AND REFERENCE WORK

Delano--American Red Cross Textbook on Home Hygiene and Care of the Sick.
American Red Cross on First Aid.
Henderson--Practical Nursing.
Dakin--Simplified Nursing.

PRACTICAL NURSING DEMONSTRATIONS

1. Protection against infection: Care of hands, abrasions, disinfectants, preparation of solutions.
2. Care of patients' rooms: Dusting, care of furniture, ventilation, temperature.
3. Care of bathrooms and utensils; care of utility rooms and utensils.
4. Care of linen closet; care of patient's clothes closet; listing patient's clothes.
5. Care of medicine cupboard; care of diet pantries, refrigerators, sinks, etc.

6-7. Bed making, with and without patient; ether bed, etc.

8. Daily toilet of patient; bed bath; foot bath; sitz bath.
9. Care of hair: Shampoo, larkspur cap.
10. Bed sores: Cause, prevention, relief of pressure, cleanliness.

11-12. Preparation of surgical supplies.

13. Taking pulse, temperature and respiration; care of clinical thermometer.
14. Charting.

15-16. Administration of medicines.

17. Enemata: Care of equipment, kind of soap, temperature.
18. Douches: Care of equipment, strength of solution and temperature.
19. Hot water bags.
    Poultices: Linseed, mustard, etc.
20. Fomentations, compresses, counterirritants, mustard plaster, iodine, etc.
21. Cold applications: Ice bags, cold sponge, tepid sponge; especial attention to temperature of cold baths.
22. Use of bed pan; after care of patient.
    Care of infected stools, sputum cups, rubber sheets and tubing.
23. Care of mattresses, linen and blankets.

24-25. Making patient comfortable in bed: Bed rest, foot sling, rubber rings, cradles, etc. Getting patient up in a chair.

26. Surgical positions for examination, treatment and drainage.
27. Splints, extensions, sand bags, etc.
28. Preparation of patient for medical examination.
29. Feeding helpless patients.
30. Special nursing care of pneumonia patients: Pneumonia jacket, temperature of room, supply of fresh air, position, crisis, etc.
31. Special nursing care of typhoid patient: Care of excreta, baths, observation of symptoms, hemorrhage, perforation, etc.
32. Special nursing care of patients suffering from respiratory and heart conditions.

33-39. Medical first aid emergencies; surgical first aid emergencies.

40-54. Obstetrics: Preparation for delivery, preparation of bed, procedure during normal labor, procedure immediately following labor, daily care of mother, care of breasts, vulva dressings, application of binders.
Daily care of infant: Care of cord, prophylactic treatment of eyes.
55. Special instruction on care of pre-school child.
56. Special instruction on modern care of tuberculosis.
57. Simple occupations for convalescents and children.
58-61. Bandaging: Roller, triangle, sling, plaster of paris, etc.
62-63. Laboratory specimens: Sputum, vomitus, feces and urine. Urinalysis.
64-66. Rules and regulations of State Department of Health.
67. Care of the dead.

HOUSEHOLD AND PERSONAL HYGIENE FOR TRAINED ATTENDANTS

1. Talk on health standards: Reasons for proper food, pure water and fresh air, sufficient sleep, normal exercise, care of hair, teeth, skin, hands and nails, proper clothes and shoes.
2. Ventilation of room; temperature of rooms in health and sickness; proper method of sweeping and cleaning; care of flowers.
3. Hygiene of food: Care of contamination of food, milk, water, ice, etc.; results of improper eating.
4. Care of refrigerator, sinks, cupboards, etc.
5. Hygiene of special senses including throat; first aid care.
6. Hygiene of generative organs: Menses and common disorders.
7-10. Talk on venereal diseases: Secure leaflets from State Department of Health, Lansing.
Communicable Diseases: Obtain printed material from State Department of Health. Teach prevention of these diseases from hygienic viewpoint.
Laws on registration of births and deaths.
Function of local Board of Health.
Function of State Department of Health.
11-13. Factors in health problems:
Heredity.
Environment.
Education: General dissemination of laws of health.
Legislation: Housing code, labor laws to regulate hours, wages and sanitary conditions; welfare laws to obtain safety devices, etc.
Disposal of sewage and garbage in homes, institutions, cities, villages and rural districts.
Sterilization, disinfection and fumigation.
14. Household hygiene: Care of toilets (seats and bowl); heating, ventilation, etc.
15. Insects, vermin, flies, mosquitoes.

ELEMENTARY ANATOMY AND PHYSIOLOGY FOR TRAINED ATTENDANTS

1. Brief talk on bony framework of the body.
2. Various tissues, joints and cavities.
3. Talk on anatomy of the organs and location in various cavities.
4. External division of the body. Definition of important terms.
5. Function of organs of respiration.
6. Function of the organs of skin; its appendages.
7. Serous, synovial and mucous membranes.
8. Function of kidneys and bladder.
9-10. Function of heart, blood and lymph.
11-12. Function of digestive organs including liver and pancreas.
13. Functions and excretions.
14. Function of special senses.
15. Generative organs.

DIETS

	Class Instruction	Practice Cooking
Essential composition of food. Its relation to growth, repair of the tissues of the body.	2 hours	
How to cook the foods which are classified as proteins. Use of protein in the body tissues--Eggs, meat, poultry, fish, etc. Use of milk.	1 hour	4 hours
How to cook foods with high proportion of starch. Use of starchy foods in the body tissues.	1 hour	3 hours
How to cook vegetables. Use of vegetables in the body. Cellulose, vitamin, minerals, etc.	1 hour	2 hours
How to prepare fruit for serving. Use of various fruits and sugars.	1 hour	1 hour
Fats, oils and salads. Proper place in dietary for the well and for the sick.	1 hour	1 hour
Beverages--Tea, coffee, etc. Liquid diets, soups, gelatines, ice cream, etc.	1 hour	2 hours
Diets for typhoid, diabetes, nephritis, tuberculosis, etc.	1 hour	4 hours
Preparation of milk for infants. Additional foods up to two years of age.	1 hour	3 hours

ETHICAL STANDARDS FOR TRAINED ATTENDANTS

1. Law regulating registration of nurses, trained attendants and practical nurses.
2. The special field of the trained attendant.
3. Principles of conduct.
4. Relation of trained attendant to patient.
5. Relation of trained attendant to physician.
6. Relation of trained attendant to registered nurse.
7-8. Etiquette in hospital and home.

SAMPLE OF CERTIFICATE

NAME OF HOSPITAL
NAME OF CITY
NAME OF STATE

THIS IS TO CERTIFY THAT. . . . . .

has completed a . . . . . months' course of instruction and practice in nursing as a TRAINED ATTENDANT and is entitled to this certificate.

Dated this . . . . . day of. . . . . 19 . .

. . . . . .
Pres. Board of Trustees.

. . . . . .
Supt. of Hospital.

(Seal of Institution)

. . . . . .
Pres. Medical Staff.

. . . . . .
Supt. of Nurses.

APPENDIX E

CURRICULUM

OF THE

TRAINING SCHOOL

PONTIAC STATE HOSPITAL

1936

PONTIAC STATE HOSPITAL

PONTIAC, MICH.

Dr. Perry V. Wagley
Superintendent

Bartlet Wager
Steward

April 18th, 1936.

Dr. P. C. Robertson, Med. Supt.,
Ionia State Hospital,
Ionia, Mich.

Dear Doctor Robertson:-

In answer to your letter of the 16th regarding our Training School, would advise you as follows:

In 1927 we changed our school to meet the standard of minimum requirements for accredited nursing schools of mental hospitals established by the American Psychiatric Association in June, 1923.

As you perhaps know this standard is no longer in existence because the American Psychiatric Association no longer follows any definite curriculum but have returned to a regular R.N. nurses course.

We cannot meet the requirements of a course in registered nursing because of lack of nurses home and other things, therefore we have continued to follow the regular two-year course which is outlined on the attached sheets.

At the beginning of each year I have prepared a number of lectures which you will note on the page marked No. 1. I require all the graduate nurses to take this course once a year to keep up with the new things in psychiatry which pertain to nurses. Pages 2 and 3 are our regular nurses courses, one year for juniors and one for seniors. We require every employee interested in nursing who wish advancement, to take this course. Their promotions depend upon their passing these courses, junior and senior years in the training school, and upon their length of time in the service also.

The requirement is a high school education.

Personally I think this plan better than the regular registered nursing course, so far as benefit derived for patients is concerned. Every employee in this institution who holds a responsible position is a graduate of our own Training School, including the Superintendent of Nurses.

We have an adequate consultant staff so that our nurses get a sufficient amount of training in the specialities.

If there are any other questions you would like to ask please feel free to do so and I will be glad to tell you whatever you desire to know.

Very truly yours,

P. V. Wagley
Med. Supt.

PVW/Van.

PSYCHIATRY

JUNIORS & SENIORS —— 1935-36

SUBJECTS	LECTURER	HOURS	DATE
Psychoneurosis	Dr. Wagley	Lectures 9:00 to 11:00 A. M. Lecture and demonstration	August 19, 1935
General Paralysis	Dr. Kelly	Lectures 9:00 to 11:00 A. M. Lecture and demonstration	August 20, 1935
Schizophrenia	Dr. Butler	Lectures 9:00 to 11:00 A. M. Lecture and demonstration	August 21, 1935
Paranoia and paranoid conditions	Dr. Glenn	Lectures 9:00 to 11:00 A. M. Lecture and demonstration	August 22, 1935
Manic Depressive psychosis	Dr. Rooks	Lectures 9:00 to 11:00 A. M. Lecture and demonstration	August 23, 1935
Senile psychosis	Dr. MacKenzie	Lectures 9:00 to 11:00 A. M. Lecture and demonstration	August 24, 1935
Organic and traumatic psychosis	Dr. Wagley	Lectures 9:00 to 11:00 A. M. Lecture and demonstration	August 26, 1935
Alcoholic psychosis	Dr. Kelly	Lectures 9:00 to 11:00 A. M. Lecture and demonstration	August 27, 1935
Schizophrenia	Dr. Butler	Lectures 9:00 to 11:00 A. M. Lecture and demonstration	August 28, 1935
Psychosis with mental deficiency and epilepsy	Dr. Glenn	Lectures 9:00 to 11:00 A. M. Lecture and demonstration	August 29, 1935
Manic depressive psychosis	Dr. Rooks	Lectures 9:00 to 11:00 A. M. Lecture and demonstration	August 30, 1935
Psychosis with cerebral arteriosclerosis	Dr. MacKenzie	Lectures 9:00 to 11:00 A. M. Lecture and demonstration	August 31, 1935

S E N I O R S — 1935 - 1936

SUBJECT	LECTURER	HOURS	NO. HRS.	DATES
SURGERY 1. Preparation & sterilization in Surgery 2. Surgical technique & minor operations 3. The operating room 4. Nursing in accidents and emergencies 5. Major operations	Dr. Wagley	Recitations 2:30 to 3:00 Lectures 3:00 to 4:00 8 recitations & demonstrations	9 hrs.	Sept. 4-6-11-13-18-20-25-27 Quiz Oct. 2, 1935
GENERAL MEDICINE 1. Local applications 2. Enema, douche, nasal feeding, etc. 3. Temperature, charting, etc. 4. Medicines, poisons and antidotes	Dr. Butler	Recitations 2:30 to 3:00 Lectures 3:00 to 4:00	12 hrs.	Oct. 4-9-11-16-18-23-25-30 Nov. 1-6-8 Quiz Nov. 13, 1935
PHYSICAL DIAGNOSIS & CHEMICAL ANALYSIS 1. Observation and examination 2. Examination of vomitus, sputum, excreta 3. Elementary bacteriology 4. Surgical bacteriology & asepsis 5. Laboratory tests	Dr. MacKenzie	Recitations 2:30 to 3:00 Lectures 3:00 to 4:00 4 recitations (Miss Bailey) 5 practical demonstrations	9 hrs.	Nov. 15-20-22-27-29 Dec. 4-6-11 Quiz Dec. 13, 1935
OCCUPATIONAL THERAPY	Miss Miller	Recitations 2:30 to 3:00 Lectures 3:00 to 4:00 Recitations & 10 practical demonstrations, 1 hr. each	4 hrs.	Dec. 18-20-23 Quiz Dec. 27, 1935
GYNECOLOGY & OBSTETRICAL NURSING	Dr. Furlong	Recitations 2:30 to 3:00 Lectures 3:00 to 4:00 Recitations & demonstrations	6 hrs.	Jan. 3-8-10-15-17 Quiz Jan. 22, 1936

S E N I O R S — 1935 - 1936

SUBJECT	LECTURER	HOURS	NO. HRS.	DATES
DIET THERAPY 1. The Normal Diet 2. Modification of the normal diet in regard to: A) Energy Content B) Protein Content C) Carbohydrate Content D) Ash Constituents 3. Vitamin Deficiency Diseases	Miss Clark	Recitations 2:30 to 3:00 Lectures 3:00 to 4:00 Four days of practical work in the diet kitchen	7 hrs.	Jan. 24-29-31 Feb. 5-7-12 Quiz Feb. 14, 1936
NEUROLOGICAL DISEASES	Dr. Rooks	Recitations 2:30 to 3:00 Lectures 3:00 to 4:00	10 hrs.	Feb. 19-21-26-28 Mar. 4-6-11-13-18 Quiz Mar. 20, 1936
EYE, EAR, NOSE & THROAT	Drs. Baker & Larson		5 hrs.	Mar. 25-27 Apr. 1-3 Quiz April 8, 1936
HYDROTHERAPY & MASSAGE 1. Baths and packs 2. Bandages and splints	Dr. Kelly	Lectures 3:00 to 4:00 Recitations 2:30 to 3:00 Recitations & demonstrations	4 hrs.	April 10-15-17 Quiz April 22, 1936
PSYCHOLOGY & SOCIAL SERVICE	Miss Davis	Recitations 2:30 to 3:00	6 hrs.	Apr. 24-29 May 1-6-8 Quiz May 13, 1935
PEDIATRICS	Dr. Cooper	Lectures 3:00 to 4:00	6 hrs.	May 15-20-22-27-29 Quiz June 3, 1936

** ALL PUPILS ARE REQUIRED TO PASS A WRITTEN EXAMINATION IN EACH OF THE ABOVE SUBJECTS WITH A MARK OF AT LEAST 70% FOR PASSING.

J U N I O R S — 1935 - 1936

SUBJECT	LECTURER	HOURS	NO. HRS.	DATES
ANATOMY	Dr. Rooks		12 hrs.	
1. General structure of human system		Recitations 2:30 to 3:00		Sept. 3-5-10-12-17-
2. The human skeleton		Lectures 3:00 to 4:00		19-24-26
3. Muscles and joints		Recitations by Supt. Nurses		Oct. 1-3-8
4. Articulation		Six demonstrations and		Quiz Oct. 10, 1935
5. Surgical anatomy, Post Mortem		recitations, 12 hrs.		
PHYSIOLOGY	Dr. Glenn		12 hrs.	
1. Organs of abdomen & pelvis		Recitations 2:30 to 3:00		Oct. 15-17-22-24-
2. Respiration and temperature		Lectures 3:00 to 4:00		29-31
3. Blood & circulatory system		Recitations by Supt. Nurses		Nov. 5-7-12-14-19
4. Urinary system		Six demonstrations and		Quiz Nov. 21, 1935
5. Digestion and absorption		recitations, 12 hrs.		
6. Skin and glands				
7. Post mortem				
MATERIA MEDICA	Dr. Butler		12 hrs.	
1. Remedial agents		Recitations 2:30 to 3:00		Nov. 26-28 Dec. 3-
2. Weights and measures		Lectures 3:00 to 4:00		5-10-12-17-19-24-
3. Medicines and their administration		Recitations by Supt. Nurses		26-31
4. Emetics, diuretics & diaphoratics		10 demonstrations, 1 hr. each		Quiz Jan. 2, 1936
5. Cardiac stimulants and sedatives				
6. Remedies improving digestion & nutrition				
7. Nerve sedatives and antiseptics				
8. Miscellaneous				

J U N I C R S — 1935 - 1936

SUBJECT	LECTURER	HOURS	NO. HRS.	DATES
CARE OF MENTAL CASES	Dr. Wagley		7 hrs.	
1. Nervous system		Recitations 2:30 to 3:00		Jan. 7-9-14-16-21-23
2. Special senses		Lectures 3:00 to 4:00		
3. Sleep and sleeplessness		Recitations by Supt. Nurses		Quiz Jan. 28, 1936
4. Classification of mental diseases				
BACTERIOLOGY	Dr. Kelly		7 hrs.	
1. Infection and immunity		Recitations 2:30 to 3:00		Jan. 30
2. Surgical cleanliness & disinfection		Lectures 3:00 to 4:00		Feb. 4-6-11-13-18
3. Practical demonstration		Recitations by Supt. Nurses		
HYGIENE & SANITATION	Dr. Michal		5 hrs.	
1. General hygiene		Recitations 2:30 to 3:00		Feb. 25-27 Mar. 3-5
2. Water and food		Lectures 3:00 to 4:00		Quiz March 10, 1936
3. Personal hygiene		Recitations by Supt. Nurses		
CHEMISTRY	Dr. MacKenzie		6 hrs.	
1. Introduction		Recitations 2:30 to 3:00		Mar. 12-17-19-24-26
2. Fundamental laws & principles		Lectures 3:00 to 4:00		Quiz March 31, 1936
3. Common elements & compounds		Recitations by Supt. Nurses		
4. Solutions, acids, bases & salts				
5. Physiological chemistry				
6. Chemistry and cleansing				

J U N I O R S — 1935 - 1936

SUBJECT	LECTURER	HOURS	NO. HRS.	DATES
NORMAL NUTRITION	Miss Clark		10 hrs.	
1. Food & Health		Recitations 2:30 to 3:00		Apr. 2-7-9-14-16-
2. Energy Requirements of Adults		Lectures 3:00 to 4:00		21-23-28-30
3. Ash Constituents & Vitamins		Recitations by Supt. Nurses		Quiz May 5, 1936
4. Nutrition at Beginning of Life		Practical demonstrations by		
5. Requirements during growth		Miss Clark		
6. Classification of Foods				
7. Summary of Digestion: Cooking Processes				
8. Serving the Tray: milk & milk products; meats				
HYDROTHERAPY	Dr. Rooks	Lectures & demonstrations	3 hrs.	May 7-12
				Quiz May 14, 1936
SOCIAL PSYCHOLOGY & ETHICS	Miss Davis		4 hrs.	May 19-21-26
HISTORY OF NURSING		Lectures 3:00 to 4:00		Quiz May 28, 1936
PRACTICAL NURSING	Mrs. Coppersmith			

*** ALL PUPILS ARE REQUIRED TO PASS A WRITTEN EXAMINATION IN EACH OF THE ABOVE SUBJECTS WITH A MARK OF AT LEAST 70% FOR PASSING.

APPENDIX F

PNEUMONIA AND TUBERCULOSIS

ONE, IN A SERIES OF LECTURES USED IN THE

ATTENDANT NURSE TRAINING PROGRAM

IONIA STATE HOSPITAL

PNEUMONIA AND TUBERCULOSIS

I. The Pneumonias

A. Lobar Pneumonia--Is an acute infectious disease caused by the pneumococcus, and characterized by a marked general toxemia, consolidation (massive congestion) of the lungs, and a high fever which usually ends by crises.

1. Etiology--The penumococcus is a lance-shaped coccus occurring in pairs (Diplococcus), gram positive and possessing a capsule or membrane surrounding the organism by means of which it can be identified by special capsule staining methods.

   Pneumonia accounts for from 5% to 10% of all deaths. The frequency of penumonia increases up to the 6th year, then falls to the 15th year when it gradually rises again especially in the later decades. Males are more frequently affected than females probably due to conditions of life. Its distribution is universal and the colored races have a higher incidence and mortality than whites.

2. Factors Increasing Liability to Disease--As the pneumococcus is frequently present in the throat of healthy persons, the factors are supposed to act by reducing the resistance of the body to its effects.

   a. Season--Incidence highest in winter and spring.
   b. Outdoor occupation shows a higher incidence.
   c. Previous attack--frequently several attacks occur--one probably predisposes to a second.
   d. Cold--Pneumonia frequently follows exposure. Cold presumably lowers resistance to infection.
   e. Debility (rundown condition) due to any cause, i.e., exhaustion, alcohol, prior diseases such as influenza, measles, etc.
   f. Trauma--An attack often follows directly upon an injury, particularly the chest.

3. Symptoms--The incubation period (time from invasion of organisms to appearance of disease) varies from a few hours to 3 or 4 days.

   The onset of the disease is sudden and usually ushered in by a severe chill lasting from 15 minutes to one hour. During the chill the temperature rises rapidly up to 104° and the patient feels acutely ill. Following this he complains of a severe pain in the side of chest, develops a short dry cough and respiration becomes rapid. Within 24 to 48 hours condition is characterized by:

a. Face flushed and eyes bright. Anxious expression to face.
b. Respiration--short and rapid. Adults 40-50, children 55-60. Frequently expiratory grunts and dilatation of nasal wings.
c. Cough--Short, frequent and repressed. Increases pain in side.
d. Sputum--Very thick and blood stained, so-called "rusty sputum" within 2 days.
e. Skin--Dry and cold sores are common.
f. Temperatures--Usually rises rapidly to about 104°, then remains rather constant between 103° and 104° until disease terminates either by crisis or lysis.
   (1) Crisis--The most remarkable phenomenon in pneumonia and probably represents the stage of active immunization built up by body against the organism. The temperature falls abruptly to normal within 6 to 12 hours--usually occurs around the 7th day of disease.
   (2) Lysis--Temperature falls more gradually, slow decline over several days--most common in children.
g. Cyanosis--May be marked due to insufficient oxygenation of blood.

4. Prognosis--The mortality of all cases at all ages is from 20% to 25%. It depends to a great extent upon; (a) age, (b) previous habits and general health of patient, (c) type of pneumococcus present. Under two years of age mortality is high. From 2 to 5 years of age fatality is rare. From 20 to 30 years about 20%; at 60 years about 60%. Habitual alcoholics, as well as those suffering from some other intercurrent disease, i.e., nephritis, diabetes, cardiac disease, and tuberculosis, succumb rapidly to the disease. Undernourished as well as stout individuals are poor subjects. Other unfavorable signs include: (a) Coma and marked delirium, (b) Extremes of temperature, i.e., above 106° or subnormal with severe toxemia (means poor body reaction), (c) Severe dyspnoea--respiratory rate over 50 per minute, (d) Absence of leucocytosis--which should normally be between 15,000 to 25,000 W.B.C.

5. Complications--In addition to the mechanical impairment resulting from consolidation to the lung as well as throwing an increased burden on the heart, the potent toxins elaborated by the pneumococcus attack particularly the nervous system, the vital centers and the muscles of the heart and blood vessels. So that failure of the circulatory system is the great danger in pneumonia.

   Complications (other diseases which may follow pneumonia) include:
   a. Pleurisy--Inflammation of the lining of the lung--always present.

b. Empyema--Pus in the pleural cavity--a common sequela--4%.
c. Perioarditis--Inflammation of lining of heart--1% serious.
d. Meningitis--Inflammation of the brain membranes--rare but serious.
e. Abscess of Lung--Rare but mortality high.
f. Gangrene of Lung--Rare but almost always fatal.

6. Treatment--Pneumonia is one of the diseases in which nursing care is probably the most important factor in getting well, and skilled nursing care can do much to give comfort and prevent complications.

Treatment may be divided into three groups:

a. Specific--Within the past decade much advance in the treatment of pneumonia has occurred with the use of specific serum therapy. Four different strains of pneumococcus have been discovered and called conveniently type I, II, III, IV. About 33% of all cases are due to type I pneumococcus; 33% to type II; 10% to type III; and about 20% to type IV, which has recently been subdivided into many different strains. Felton's serum has been prepared for each of these types so that by typing the strain of organisms present in the sputum of a case of pneumonia we can administer the corresponding type of serum. The mortality rate in pneumonia has been markedly reduced by using serum therapy--as low as 9% in type I. Obviously, to be of greatest value it must be given early in the disease--by the 3rd day if possible. The cost of the serum is as yet somewhat prohibitive.
b. General Treatment.
   (1) Rest--is absolutely essential. The patient must be spared every effort which means extra strain on the heart so that he may muster all his forces to combat the disease. If difficulty in breathing is severe, he may be placed in a semi-sitting position, well supported by pillows. Mental rest and quiet are equally essential as physical rest.
   (2) Diet--In lobar pneumonia the patient is usually very toxic. The appetite is poor, digestion impaired and course of disease short, so soft or liquid diet is sufficient. Give fluids, 3-4 quarts daily of water, lemonade, orange ade or imperial drinks.
   (3) Do not neglect the care of the mouth. Give daily enema.
   (4) Quinine--60 to 70 gr. daily for 2 or 3 days.
c. Symptomatic Treatment.
   (1) Pleurisy pain--Use external applications and counter irritants--hot pad, mustard plaster, etc. Use opiates such as codeine freely, morphine sulphate if pain is severe.

(2) Cough--Stimulating expectorants.
(3) Fever--Tepid sponge bath every 3 hours for temperature above 103°. Avoid anti-pyretics.
(4) Abdominal distension--Daily S.S. enema. Turpentines stupes. Pituitrin, 1 cc. every 3 hours with rectal tube.
(5) Cyanosis--Oxygen tent or nasal catheter.

B. Broncho-pneumonia--Similar in most respects clinically to lobar pneumonia except as to pathology which reveals scattered areas of congestion throughout the lung rather than localized areas. Broncho-pneumonia is more apt to attack the weak--infants and older people, in whom the power of heat production is very low. Usually secondary to pre-existing cold, bronchitis or as a terminal event in other debilitating diseases.

II. Tuberculosis

A chronic infectious disease caused by the tubercle bacillus characterized by its insidious onset, weakness, loss of weight and strength, poor appetite and slight afternoon temperature variation. The disease may affect almost any tissue in the body and hence is named thereby, i.e.,:

Pulmonary tuberculosis--affecting the lungs.
Tuberculosis adenitis--affecting the lymph glands.
Tuberculosis meningitis--affecting the meninges.
Tuberculosis peritonitis--affecting peritoneum.
Tuberculosis enteritis--affecting the intestines.
Tuberculosis osteitis--affecting the bones.
Pott's Disease--affecting the vertebrae.
Acute miliary tuberculosis--affecting all organs.

Tuberculosis has been known through the ages and called "The White Plague" by the early Greeks but more progress has been made towards its irradication and treatment since the discovery of the tubercle bacillus and its cause by Koch in 1882, than in all the hundreds of years previous. During the past 3 decades, through cooperation of the public health agencies, physicians throughout the world, and in education of the laity as to the nature of tuberculosis, much progress has been made in the right direction. Still, tuberculosis at present stands well up near the top of the list as causes of death. But even greater than this is the great economic burden resulting from incapacitation of the individual as well as cost of hospitalization. The annual cost of hospitalization from tuberculosis exceeds $70,000,000 in the United States. There are 471 sanitariums in the United States which admitted some 121,800 patients during the past year.

The most frequent part of the body affected is the lungs, hence we will limit our discussion to pulmonary tuberculosis.

The tubercle bacillis is rod-shaped and recognized by acid-fast stain methods, as was demonstrated in a lecture on bacteriology.

The organism is extremely resistant to heat, cold and drying. Virulent organisms capable of producing disease may be present in dried sputum after 2 months.

Conditions which predispose to the development of active tuberculosis include under-nourishment, bad ventilation, insufficient exercise, chronic debilitating diseases, subsequent to acute respiratory disease and in general anything which tends to lower one's vitality and resistance to infection.

The main path of infection in pulmonary tuberculosis is by "droplet infection" (inhaling air containing fine droplets contaminated with tubercle bacillis). It is estimated that in a single expectoration from a case in which liquifying cavitation is taking place, as many as one billion organisms may be coughed out. Ingestion of contaminated milk and food is the most frequent portal of entry for bone, joint and abdominal tuberculosis.

A. Symptoms--The onset of plumonary tuberculosis is insidious; often the first symptom noticed is a weakness or tired feeling. Patient realizes that he does not have his usual "pep" or vigor and tires more easily than usual. A considerable number of patients give a history of repeated attacks of "colds" which do not seem to clear up. Every case of chest cold which does not clear up within 2 weeks should be investigated. Probably the most frequent early symptom is a cough, or possibly nothing more than a persistent and annoying "clearing" of the throat. Grouping characteristics symptoms of pulmonary tuberculosis include:

   1. Cough--Mostly at night and early morning. Early stages: Dry and hacking. Later stages: Loose and with sputum.

   2. Sputum--Early--mucoid. Later--greenish purulent matter.

   3. Haemoptysis--(blood spitting). Onset sudden--salty taste in mouth. Sputum may be merely streaked with blood. Severe hemorrhage may cause death.

   4. Pain-Usually associated with pleurisy or from coughing.

   5. Fever--Early and important sign and the most valuable measure of severity and progress of disease. Fever is due to absorption of toxins. Afternoon rise of 1/2 to 1 degree very suggestive.

   6. Night sweats--Often drenching cold sweat during night and early morning.

   7. Loss of weight and strength--Often early symptoms--weight is important index of disease.

   8. Loss of appetite and dyspepsia.

9. Increased pulse rate--May persist when temperature is normal. With active tuberculosis rarely below 84.

10. Anemia--Muddy pallor and musty odor to skin.

B. Treatment

1. Rest is by far the most important single factor in the treatment of tuberculosis, includes mental as well as physical rest. The average early case of pulmonary tuberculosis requires approximately 2 to 3 years of intensive treatment for a complete healing--the most important part of the treatment is rest. After healing has occurred graduated exercise is begun to get the patient back to normal activity again.

2. Fresh air is very important.

3. Diet--Avoid highly seasoned, spicy, irritating foods. Otherwise regulate according to weight gain. Variety is an important factor.

4. Ultra violet light (sun baths)--are excellent when patient is not running a temperature. Dosage must be regulated carefully.

5. Pneumothorax--Collapse therapy--inject air into pleural cavity to put diseased lung at rest as well as rest of body.

6. Drugs used for symptomatic relief as needed to control cough, gastro-intestinal distress, pain, insomnia and the like.

7. Surgery has its place in treatment of certain selected cases.

APPENDIX G

CURRICULUM GUIDE

FOR

INSERVICE TRAINING OF ATTENDANT NURSES

MICHIGAN DEPARTMENT

OF

MENTAL HEALTH

1961

PREFACE

A brief review of the history of the world shows through the ages that one or another form of life rose to a position of dominance and then faded into oblivion. In examining these recurring dominant forms, one learns that each succeeding form had some characteristic that was unique and which was responsible for its power and dominance. Man is not an exception. His unique possession or characteristic which gives him dominance over other forms of life lies in his intelligence and his ability to transmit knowledge from one generation to the next.

Leaving the vast world stage and looking at the man made systems and subsystems therein, one can demonstrate the validity of the above theory that effective transmission of knowledge is essential for survival. Political, educational, and social systems thrive or fade depending on the ability they have to assimilate and transmit constantly derived new knowledge.

The Department of Mental Health is no exception to this rule. We can only provide the best possible care and treatment, and insure early return of our patients to their homes, by constantly seeking new knowledge and transmitting this to one another. The profession of nursing, which plays so vital a role in the treatment of our patients has, in recent years, acquired significantly different forms of knowledge concerning patient care. Specifically, the profession is moving away from the older functional categorizations of classical nursing practice characterized by structural compartmentization into nursing administration, nursing education, bedside nursing, and the like; and developing a concept of clinical nursing practice with major emphasis on the acquisition and utilization of clinical skills. Present knowledge suggests that patients improve with the help of nurses practicing nursing in a clinical setting and a review of the contents of this curriculum indicates that the committee has taken this new knowledge and approach into consideration in developing this curriculum guide.

We should make every effort to implement this curriculum as rapidly as possible, since it is only through the use of new techniques and methods that we can obtain new knowledge that will lead the way to further progress.

Vernon Stehman, M.D.
Deputy Director
Michigan Department of
Mental Health

INTRODUCTION

The need for a curriculum guide has been recognized by those charged with the responsibility for providing an effective inservice education program for attendant nurses caring for patients in our state hospitals and training schools. The responsibility of nursing education has been clearly outlined in the nursing program guide of the Department of Mental Health: "Nursing education has the responsibility for improving patient care by providing on-going clinical education for the various levels of nursing personnel and nursing students."[1]

In order to meet this responsibility, a committee was appointed to develop a curriculum which would promote consistency in the training of attendant nurses throughout the various institutions of the Department of Mental Health. Such a curriculum would be of inestimable value in providing a guide for the instructor and in promoting continuity in the programs.

Many recommendations and topical outlines for basic attendant nurse training have been developed by various groups. Among the outlines utilized in the preparation of the curriculum guide are a Suggested Curriculum for In-Service Training of Psychiatric Aides, prepared by Sub-Committee Psychiatric Aide Education and Practical Nurse Education of the Michigan League for Nursing and, A Project in Pre-Service Psychiatric Aide Education, prepared under the direction of the College of Nursing, Wayne State University, 1960.

The curriculum guide consists of three sections; (1) Orientation, (2) Fundamentals of General Nursing and (3) Fundamentals of Psychiatric Nursing. Section One has been planned to meet the needs of the attendant nurse who is new to the hospital. Upon completion of the Orientation, the attendant nurse should be able to perform simple nursing procedures and to assist the ward staff under the direction of the ward supervisor. It should be noted that the administration of medications is not a part of the Orientation.

Sections Two and Three have been planned with enough flexibility in time and content to allow for meeting the specific needs of individual institutions. Upon completion of sections Two and Three, the attendant nurse should have a better understanding of and ability to provide safe patient care.

The curriculum guide includes only that material necessary to provide for a basic training program for attendant nurses. Those demonstrating ability to advance beyond this level would then be given additional courses in advanced nursing arts procedures, in psychiatric nursing, and in principles of supervision and administration.

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[1] Program Guide Nursing, Department of Mental Health, State of Michigan, Lansing, January, 1960, p. 11.

The curriculum guide outlines what we believe to be appropriate. The institutions that need to will add content to meet their individual needs. In implementation of the curriculum it is recommended that:

1. Training wards be established to provide supervised clinical practice.

2. Employees be assigned to the educational department during their educational program.

3. Section One, Orientation, be initiated immediately upon employment.

4. Sections Two and Three, Fundamentals of General Nursing and Fundamentals of Psychiatric Nursing, be initiated as soon as possible, and preferably by the time the attendant nurse has satisfactorily completed the six-month probationary period.

5. The Department of Mental Health establish a standing committee with representation from Nursing Education and Nursing Service to study, assist and make recommendations for the implementation of the curriculum.

The committee wishes to express its appreciation to all who have assisted in the preparation of the curriculum guide. We especially wish to thank Miss Doris Haid, Associate Professor of Psychiatric Nursing, Wayne State University, for the guidance she has given us.

Subcommittee on Curriculum
Attendant Nurse Inservice Education Group
Michigan Department of Mental Health

SECTION I

ORIENTATION

I. INTRODUCTION TO COURSE

II. INTRODUCTION TO HOSPITAL

III. INTRODUCTION TO NURSING DEPARTMENT

IV. INTRODUCTION TO ASSIGNED CLINICAL AREA

V. PERSONAL HYGIENE FOR EMPLOYEE

VI. SUGGESTED NURSING PROCEDURE CHECK LIST

VII. SUGGESTED TWO-WEEK CLASS SCHEDULE

SECTION I

ORIENTATION

40 hours theory
40 hours clinical practice

Objectives:

To become acquainted with the philosophy and goals of nursing within the Department of Mental Health

To become acquainted with the hospital, its organization and functions

To develop understanding of the policies, rules and procedures essential to the operation of the hospital

To develop understanding of the functions of the psychiatric attendant nurse on the hospital nursing team

To develop an awareness of basic nursing techniques necessary for the care, comfort and safety of the patient

Content	Learning Experiences and Methods
I. INTRODUCTION TO COURSE A. PURPOSES B. COURSE DESCRIPTION C. SCHEDULING D. OTHER INSERVICE EDUCATION PROGRAMS AVAILABLE TO ATTENDANT NURSE	Lecture and discussion

Content	Learning Experiences and Methods
II. INTRODUCTION TO HOSPITAL	
A. RELATIONSHIP TO DEPARTMENT OF MENTAL HEALTH	Lecture and discussion
B. BRIEF HISTORY	
C. PURPOSE AND PHILOSOPHY	
D. ORGANIZATION	
1. Services (Departments)	Lecture by medical superintendent
a. relationships between departments	
b. major responsibilities	
c. administrative personnel	
2. Physical structure	Tour of the hospital
E. POLICIES	Lecture by personnel director
1. Civil service personnel policies	
2. Hospital policies	
F. SAFETY DEPARTMENT	Lecture by representative of the Safety Department
1. Safety regulations	
2. Accident prevention	
3. Fire prevention	Demonstration of the use of fire alarm box
III. INTRODUCTION TO NURSING DEPARTMENT	
A. ORGANIZATIONAL STRUCTURE	
1. Philosophy, purposes, goals	Lecture by director of nursing
a. nursing service	
b. nursing education	Assignment: Robinson, The Psychiatric Aide. A Textbook for Patient Care

Content	Learning Experiences and Methods
2. Relationships (intra-and interdepartmental) a. lines of communication b. nursing team concept c. role of attendant nurse	Review of job description
B. PHYSICAL ORGANIZATION OF WARDS FOR VARIOUS SERVICES	
C. PROCEDURES AND POLICIES 1. Manuals 2. General and specific policies for patient care	Demonstration of use of procedure and policy manuals
3. General nursing personnel policies a. staffing b. assignments c. schedules	Assignment: Read and discuss Department of Mental Health's Policy Letter on Abuse of Patients
D. INTERPERSONAL RELATIONSHIPS 1. Factors which influence 2. Characteristics of good human relationships	Lecture and discussion
3. Results of faulty interpersonal relationships	Assignment: M. O. Weiss, Attitudes in Psychiatric Nursing
E. APPROACHES TO PATIENTS	
IV. INTRODUCTION TO ASSIGNED CLINICAL AREA	Introduction to patients and ward personnel on assigned ward
A. PERSONNEL 1. Staffing 2. Assignments 3. Schedules	Conference with ward supervisor

Content	Learning Experiences and Methods
B. PHYSICAL FACILITIES	Tour of the ward
C. THERAPEUTIC ENVIRONMENT 1. Definition 2. Characteristics a. provides for meeting needs of patients b. provides safety c. provides cleanliness and comfort d. provides security e. provides opportunity for satisfying relationships	Lecture and discussion Assignment: Stern and Corcoran, Working in a Mental Hospital Ward conference: Observations of nursing team, participation as a member of the team, relationships of nursing personnel
D. NURSING PRINCIPLES BASIC TO PATIENT CARE	
E. BEHAVIOR PATTERNS OF PATIENTS	
F. RECORDS	
G. NURSING SKILLS AND PROCEDURES 1. Bed making 2. Bathing 3. Personal hygiene 4. Vital signs 5. First aid 6. Feeding of patients 7. Specialing patients 8. Enemata 9. Application of heat and cold 10. Preparing and escorting patients 11. Care for patient with seizures 12. Care for suicidal patient	Supervised ward practice Demonstration and return demonstration of selected nursing procedures

Content	Learning Experiences and Methods
13. Body mechanics 14. Emergency nursing procedures 15. Observation 16. Recording	
H. PLANNING NURSING CARE	Participation in planning approaches to patient care
V. PERSONAL HYGIENE FOR EMPLOYEE	
A. UNIFORM	Self-evaluation of health habits
B. GOOD HEALTH HABITS	

SUGGESTED CLASS SCHEDULE

1st Week Orientation

MONDAY	TUESDAY
Class - 2 hrs Introduction - Keys Introduction to course Coffee Break Class - 2½ hrs Introduction to hospital organization and structure Personnel Director Civil Service policies Hospital policies Lunch Class - 1½ hrs Introduction to hospital's physical plant (ct'd) Tour of administrative facilities and other pertinent areas (Class - 6 hrs)	Class - 2 hrs Introduction to Nursing Dept. Coffee Break Class - 1 hr Safety Department demonstration Ward Practice Introduction to personnel Tour of ward facilities Lunch Class - 3 hrs Demonstration and practice - bed making Interpersonal Relationships Role of the attendant nurse (Class - 6 hrs)

2nd Week Orientation

Ward Practice Class - 2 hrs First aid Lunch Ward Practice Class - 2 hrs Observation and recording (Class - 4 hrs)	Ward Practice Class - 2 hrs Emergency nursing procedures - Seizure patients Suicidal patients Lunch Class - 1 hr Feeding of patients Ward Practice (Class - 3 hrs)

SUGGESTED CLASS SCHEDULE

1st Week Orientation

WEDNESDAY	THURSDAY	FRIDAY
Class - 2 hrs Interpersonal Relationships (ct'd) Behavior patterns of patients Coffee Break Class - 2 hrs Use of procedure manual Demonstration - bed bath Lunch Ward Practice Class - 2 hrs Vital signs (Class - 6 hrs)	Ward Practice Coffee Break Class - 2 hrs Vital signs (ct'd) Demonstration and practice Lunch Class - 3 hrs Therapeutic environment Personal hygiene of patient and employee (Class - 5 hrs)	Ward Practice Coffee Break Class - 2 hrs Approaches to patients Lunch Class - 3 hrs Body mechanics principles, demonstration and practice (Class - 5 hrs)

2nd Week Orientation

Ward Practice Class - 2 hrs Planning nursing care Lunch Class - 1 hr Planning nursing care (ct'd) Ward Practice (Class - 3 hrs)	Class - 1 hr Written exam Class - 1 hr Director of nursing Hospital superintendent Lunch Ward Practice (Class - 2 hrs)	Ward Practice Individual conferences for evaluation and assignment

SAMPLE
NURSING PROCEDURE CHECK LIST
ORIENTATION

NAME: DATE:

	Observed	Supervised	Practiced
TRANSFER OF PATIENTS			
BODY CARE			
ORAL HYGIENE			
TUB BATH			
SHOWER			
BED BATH			
DRESSING			
SHAVING			
NAIL CARE			
UNTIDINESS			
FEEDING			
ASSISTED			
SPOON			
ACTIVITY			
ESCORTING TO CLINICS			
MOVING IN BED			
WALKING			
BED MAKING			
OCCUPIED			
UNOCCUPIED			
MAINTENANCE OF SUPPLIES & EQUIPMENT			
WARD HOUSEKEEPING			
CARE OF LAUNDRY AND SOILED LINEN			
FIRE PREVENTION			
SUPERVISION OF SMOKING			
SECLUSION			
MANUAL RESTRAINT			
* TEMPERATURE, PULSE, RESPIRATION AND BLOOD PRESSURE			
* CHARTING			
ENEMA			
APPLICATION OF HEAT AND COLD			

When new attendant performs the procedure satisfactorily, place a small ✓, date and initials of supervisor should be placed in supervised column.

* TO BE RECHECKED BY ATTENDANT INSTRUCTOR OR REGISTERED NURSE ON WARD. This form is to be kept on ward. The proper columns are to be checked when procedure is observed, supervised, or practiced.

TEACHING AIDS

A. Books, Phamphlets, Mimeographed Materials

1. Goulding, Forn and Torrop, Hilda. The Practical Nurse and Her Patient, Philadelphia: J. B. Lippincott, 1955.
2. Hospital Map
3. Hospital Organization Chart
4. Hospital Policy Manual
5. Hospital Procedure Manual
6. Leake, Mary. Simple Nursing Procedures, 3rd ed., Philadelphia: W. B. Saunders Company, 1961.
7. Nursing Department Organization Chart.
8. Robinson, Alice. The Psychiatric Aids, A Textbook for Patient Care, 2nd ed., Philadelphia: J. B. Lippincott, 1959.
9. Samples of Hospital Forms and Records.
10. State of Michigan, Department of Mental Health. Program and Activities, Lansing: 1960.
11. State of Michigan. Rules of the Civil Service Commission, Lansing: 1960.
12. State of Michigan. Grievance Procedure, Civil Service Commission.
13. Stern, Edith and Corcoran, Mary. Working in a Mental Hospital, New York: The National Association for Mental Health, 1955.
14. Thompson, Ella and LeBaron, Margaret. Simplified Nursing, 7th ed., Philadelphia: J. B. Lippincott, 1960.

15. Weiss, Madeline. Attitudes in Psychiatric Nursing Care, New York: G. P. Putnam's Sons, 1954.

B. Films
Department of Mental Health, Education Section

1. It's a Big Problem

2. Man to Man

3. Nurse-Patient Relationships in Psychiatric Nursing

SECTION II

FUNDAMENTALS OF GENERAL NURSING

I. PATIENT CENTERED CARE IN NURSING PROCEDURES

II. PATIENT'S ENVIRONMENT

III. BODY STRUCTURE AND FUNCTION

IV. SIGNS AND SYMPTOMS OF MALFUNCTION

V. PHYSICAL AND PSYCHOLOGICAL CARE OF PATIENTS

VI. PERSONAL HYGIENE PROCEDURES

VII. NUTRITIONAL NEEDS OF PATIENTS

VIII. BASIC NURSING PROCEDURES

IX. EMERGENCY CARE

X. OBSERVING, REPORTING AND RECORDING SYMPTOMS, REACTIONS AND CHANGES

SECTION II

FUNDAMENTALS OF GENERAL NURSING

80 hours theory
160 hours clinical practice

Objectives:

To develop ability to provide for the physical and psychological comfort and safety of patients

To develop beginning skills necessary to perform basic nursing procedures

To gain elementary knowledge of body structure and function

To develop the ability to recognize signs and symptoms of the more common illnesses

To develop the ability to observe, report and record symptoms, reactions and changes

To gain appreciation of the nutritional needs of the body

To develop an understanding of emergency care

Content	Learning Experiences and Methods
I. PATIENT CENTERED CARE IN NURSING PROCEDURES	
A. PHYSIOLOGICAL SIGNIFICANCE B. PSYCHOLOGICAL SIGNIFICANCE C. SOCIAL SIGNIFICANCE D. BACTERIOLOGICAL SIGNIFICANCE	Lecture and discussion Reference assignment

Content	Learning Experiences and Methods
II. A. EFFECT ON PHYSICAL AND MENTAL WELL BEING	Lecture and discussion
B. CARE OF UNIT 1. Cleanliness 2. Safety 3. Orderliness 4. Temperature 5. Ventilation	Orientation to ward
C. CARE OF HOSPITAL EQUIPMENT	
D. CARE OF PATIENT'S CLOTHING AND POSSESSIONS	
III. BODY STRUCTURE AND FUNCTION	Lecture and discussion
A. GENERAL PLAN OF THE BODY 1. Body wall 2. Body cavities and organs 3. Extremities 4. Systems of the body a. names b. functions	
B. ORGANIZATION OF THE STRUCTURE 1. Cell 2. Tissue 3. Organ 4. System	
C. GENERAL BODY FUNCTION 1. Characteristics of all living matter a. metabolism b. movement	

Content	Learning Experiences and Methods
c. irritability d. conductivity e. integration f. reproduction 2. Compounds and their functions in living matter a. water b. proteins c. carbohydrates d. fats	
D. INTERRELATEDNESS OF STRUCTURE AND FUNCTION 1. Interdependence of body systems 2. Function of human body as total organism	
IV. SIGNS AND SYMPTOMS OF MALFUNCTION	
A. INTERRUPTION OF USUAL HABITS 1. Sleeping 2. Eating 3. Exercise 4. Elimination 5. Socialization	Lecture and discussion
B. COLOR AND CONDITION OF SKIN, LIPS, NAILS	
C. LOCATION, CHARACTER, DURATION, AND FREQUENCY OF PAIN	
D. CHARACTER OF VITAL SIGNS 1. Blood pressure 2. Temperature 3. Pulse 4. Respiration	

Content	Learning Experience and Methods
E. CHARACTER, FREQUENCY, AND AMOUNT OF EXCRETIONS 1. Perspiration 2. Expectoration 3. Emesis 4. Defecation 5. Urination	
F. INFLAMMATION 1. Definition 2. Causes 3. Signs a. heat b. swelling c. redness d. pain	
G. STRUCTURAL CHANGES 1. Edema 2. Growths 3. Fractures and dislocations	
V. PHYSICAL AND PSYCHOLOGICAL CARE OF PATIENTS	Lecture and discussion
A. BODY MECHANICS	Review procedure book
B. MECHANICAL DEVICES	Classroom demonstrations
C. SAFETY PRECAUTIONS 1. Use of restraints and sideboards 2. Prevention of accidents 3. Prevention and control of fires 4. Checking sharps and keys	Reference assignment

Content	Learning Experience and Methods
D. DIVERSIONAL AND SOCIAL ACTIVITIES	
VI. PERSONAL HYGIENE PROCEDURES	
A. BATHS	
B. ORAL HYGIENE	
C. SKIN CARE AND GROOMING	
D. PREVENTION OF DECUBITI	
VII. NUTRITIONAL NEEDS OF PATIENTS	Lecture and discussion
A. BASIC ADEQUATE DIET	Tour of food preparation area
B. SPECIAL DIETS	Explanation of various diets and dietary procedures by dietitian
C. NUTRITIONAL DEFICIENCIES	Reference assignments
VIII. BASIC NURSING PROCEDURES	Lecture and discussion
A. PREPARATION OF PATIENT FOR PROCEDURES 1. Explanation of procedure 2. Need for privacy	Review procedure book
B. ADMINISTRATION OF MEDICINES 1. Definitions and abbreviations 2. Types and methods of preparation 3. Methods of administration 4. Physician's orders 5. Action of drugs	Lecture and discussion Classroom demonstrations Reference assignment

Content	Learning Experiences and Methods
6. Computation of dosages	Class practice on computation
7. Recording and reporting	
8. Care of medicine cabinet	
C. CARRYING OUT AND ASSISTING WITH DIAGNOSTIC PROCEDURES	Lecture and discussion
1. Blood pressure, temperature, pulse, respiration	
a. definitions	Review procedure book
b. mechanics of operation	
c. reporting and recording	Classroom demonstration
2. Weights and measurements	
3. Collecting and testing specimens	Reference assignment
4. Assisting physician, nurse, or technician	
a. physical examination	
b. x-ray examination	
c. laboratory procedures	
D. ASEPTIC TECHNIQUE	Lecture and discussion
1. Definition	
2. Principles	
E. PRINCIPLES AND TECHNIQUES OF ISOLATION	Lecture and discussion
1. Indication for use	
2. Procedures	Review procedure book
a. setting up isolation unit	
b. use of gown and mask	Classroom demonstration
c. handwashing	
d. disinfection of equipment and utensils	
F. MEAL SERVICE	
1. Serving food	
2. Spoon feeding	
3. Tube feeding	

Content	Learning Experiences and Methods
G. ROUTINE NURSING PROCEDURES 1. Bed making 2. Enemata 3. Dressings 4. Catheter irrigation 5. Applications of heat and cold 6. Feeding patients 7. Suction apparatus 8. Care of patients in casts 9. Sponges 10. Sitz baths 11. Moving patients 12. Care of decubiti 13. Tube feedings 14. Use of orthopedic devices 15. Post mortem care	Lecture and discussion Review procedure book Demonstrations
H. MOVEMENT OF PATIENTS	
I. CARE OF SURGICAL PATIENT	
J. RELIGIOUS RITES	
IX. EMERGENCY CARE	Lecture and discussion
A. DEFINITION	
B. ALTERCATIONS 1. Individual 2. Group 3. Anticipation and prevention	

Content	Learning Experiences and Methods
C. MEDICAL EMERGENCIES 1. Hemorrhage 2. Shock 3. Cuts and wounds 4. Injuries to bones and joints 5. Burns 6. Cardiac failure 7. Asphyxiation 8. Foreign bodies in eye, ear, nose, throat	Lecture and discussion Review procedure book Demonstration Reference assignment
D. PSYCHOLOGICAL REACTION TO EMERGENCIES	
X. OBSERVING, REPORTING AND RECORDING SYMPTOMS, REACTIONS AND CHANGES	
A. IMPORTANCE OF OBSERVATION AND REPORTING	Practice in charting and reporting
B. AREAS OF OBSERVATION 1. Appearance 2. Behavior 3. Conversation	Reference assignment
C. CONDITIONS DEMANDING IMMEDIATE ACTION AND NOTIFICATION	
D. OBJECTIVITY IN OBSERVATION AND REPORTING 1. Use of correct terminology 2. Use of direct quotations 3. Avoidance of subjective interpretation	
E. RECORDS AS LEGAL DOCUMENTS	

Content	Learning Experiences and Methods
F. TECHNIQUES AND METHODS OF COMMUNICATION 1. Charts 2. Kardex 3. Nursing care plan 4. Oral and written reports 5. Other lists and records	Lecture and discussion

TEACHING AIDS

A. Books, Pamphlets, Mimeographed Materials

1. American Red Cross. First Aid Manual, New York: Doubleday and Co., 1957.

2. Charts of Equivalances

3. Charts on Foods

4. Dakin, Florence and Thompson, Ella. Simplified Nursing, 6th ed., Philadelphia: J. B. Lippincott, 1956.

5. Goulding, Forn and Torrop, Hilda. The Practical Nurse and Her Patient, Philadelphia: J. B. Lippincott, 1955.

6. Hospital's Procedure Book

7. Information on Commonly Used Drugs

8. Ingram, Madelene E. Principles and Techniques of Psychiatric Nursing, 5th ed., Philadelphia: W. B. Saunders Co., 1960.

9. Leake, Mary. Simple Nursing Procedures, 3rd ed., Philadelphia: W. B. Saunders Co., 1961.

10. Memmler, Ruth L. The Human Body in Health and Disease, Philadelphia: J. B. Lippincott, 1959.

11. Metropolitan Life Insurance, N. Y. Company Pamphlets.

12. Michigan League for Nursing. Manual on Disaster Nursing, Lansing, Michigan.

13. Montag, Mildred and Filson, Margaret. Nursing Arts, Philadelphia: W. B. Saunders Co., 1959.

14. Otto, James H., Julian, Cloyd J., and Tether, Edward J. Modern Health, New York: Henry Holt & Co., 1955.

15. Pretest

16. Robinson, Alice. The Psychiatric Aide, A Textbook for Patient Care, 2nd ed., Philadelphia: J. B. Lippincott, 1959.

17. Shafer, Kathleen; Sawyer, Janet; McCluskey, Audrey; Lifgren, Edna. Medical-Surgical Nursing, St. Louis: C. V. Mosby Co., 1958.

18. Steele, Katherine and Manfreda, Marguerite. Psychiatric Nursing, 6th ed., Philadelphia: F. A. Davis Co., 1959.

19. Symbols and Abbreviations.

20. Thompson, Ella M. and LeBaron, Margaret. Simplified Nursing, 7th ed., Philadelphia: J. B. Lippincott, 1960.

B. Films:

Balance in Action

Vital Signs and Their Interpretation

SECTION III

FUNDAMENTALS OF PSYCHIATRIC NURSING

I. INTRODUCTION

II. GROWTH AND DEVELOPMENT

III. SIGNS AND SYMPTOMS OF MENTAL ILLNESS

IV. DEVIATE PATTERNS CF BEHAVIOR

V. EPILEPSY

VI. MENTAL RETARDATION

VII. CLASSIFICATION OF MENTAL ILLNESS

VIII. THERAPIES

IX. REHABILITATION

X. LEGAL ASPECTS

SECTION III

FUNDAMENTALS OF PSYCHIATRIC NURSING

80 hours theory
160 hours practice

Objectives:

To develop a better understanding of himself and others

To gain an understanding of basic psychiatric and mental health concepts and principles

To acquire beginning skills in interpersonal relationships

To develop ability to recognize the needs of the patient

To develop a beginning understanding of the causes, classification and treatment of mental illness and mental retardation

To develop an appreciation of the roles of other disciplines

To develop awareness of community resources available for rehabilitation of the patient

Content	Learning Experience and Methods
I. INTRODUCTION	
A. HISTORICAL ASPECTS OF PSYCHIATRIC NURSING 1. Primitive peoples 2. Ancient civilizations 3. Early Christians 4. Contemporary approach	Lecture and discussion

Content	Learning Experiences and Methods
a. from custodial to therapeutic care b. from state hospital to community involvement c. team concept 5. Personalities in psychiatry	
B. CULTURAL INFLUENCES ON THINKING 1. Behavior variations and individual differences result of hereditary endowment plus environmental influences 2. Cultural milieu a. geographical influences b. social heritage transmitted by learning 1. knowledge 2. beliefs 3. mores 4. laws 5. customs 6. modes of communication c. major area of cultural development 1. ability to manipulate environment by use of hands 2. ability to speak and communicate ideas 3. Motivation of human behavior related to cultural heritage and development a. need for new experiences b. need for security c. need for response d. need for recognition 4. The family as a cultural influence on thinking 5. Group influences on thinking a. groups originate to satisfy man's needs 1. primary groups 2. secondary groups	Lecture and discussion Ward conference: Ethnic groups in local community

Content	Learning Experiences and Methods
b. groups exert social pressure and control on individuals and uphold traditions 6. Social structure of the hospital	
C. ATTUTUDES 1. Definition of attitude 2. Types of attitudes 3. Use of attitudes in specific situations 4. Use of specific therapeutic attitudes in interpersonal relations	Lecture and discussion Ward conference: Analysis of specific attitudes in patient care Reference assignment
D. ROLES OF THE ATTENDANT NURSE 1. Protection of patient a. prevent combative, destructive behavior b. prevent suicide and injury c. make decisions where necessary to protect patient against judgmental defects d. provide safe, simple, regulated daily 2. Supervision of personal hygiene a. maintain dietary and fluid intake b. encourage and supervise rest, exercise, c. supervise toiletry 3. Activation of patient a. establish positive rapport b. give realistic praise and encouragement c. adopt an accepting, non-judgmental attitude d. provide assurance e. redirect expression of emotional tension into constructive channels f. set limits for behavior g. stimulate recreational and occupational interest h. help patient maintain contact with reality i. encourage socialization	Lecture and discussion Ward conference: Analysis of role of attendant in activities Reference assignment: Gregg, "The Psychiatric Nurse's Role" Assignment: Diary of day's activities of attendant nurse

Content	Learning Experiences and Methods
4. Participation in routine and diagnostic measures a. explain treatments and procedures b. communicate observations	
E. ETHICS 1. Definition 2. Ethical obligations in relationships a. to patient b. to personnel c. to patient's family 3. Ethical obligation concerning a. records b. communication c. promotion of total hospital program 4. Ethical responsibilities to self a. in job performance b. in handling personal problems c. in controlling emotions	Lecture and discussion Reference assignment: Robinson, The Psychiatric Aide
F. THERAPEUTIC ENVIRONMENT 1. Definition a. physical properties b. dynamic qualities 2. Characteristics a. provision for day by day living b. provision for protection of patient 1. from injury or self mutilation 2. from harming others 3. from anxieties of former environment 4. from somatic disorders and infection 5. from decisions beyond his responsibility 6. from indiscriminate confession	Lecture and discussion Ward conference: Analysis of observations of various relationships, e.g., patient-staff, patient in group Ward conference: Analysis of a day's program of activities and provision for consideration of individual and group needs Reference assignment

Content	Learning Experiences and Methods
c. provision of testing ground for establishment of new patterns of behavior d. provision of selected experiences and activities to help him participate and communicate e. acceptance of the individual with rights, needs, opinions f. consideration of individual differences and needs as well as group needs g. democratic management with fewer restrictions and increasing freedom of choice as patient is able to assume responsibility 3. Responsibilities for maintaining the therapeutic environment a. hospital and nursing administration 1. policies, functions, responsibilities defined 2. identification and focus of problems 3. promotion of consistency and stability 4. promotion of dynamic program b. individual employee responsibility	Assignment: Diary of day's activity of attendant nurse

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A. Books, Pamphlets and Mimeographed Materials

1. Attendant Nurse Job Descriptions.

2. Belknap, Ivan. Human Problems of a State Mental Hospital, New York: McGraw-Hill Book Co., Inc., 1956.

3. Brown, Martha M. and Fowler, Grace R. Psychodynamic Nursing 2nd ed., Philadelphia: W. B. Saunders Co., 1961.

4. Greenblatt, Milton, York, Richard H. and Brown, Esther Lucile. From Custodial to Therapeutic Patient Care in Mental Hospitals, New York: Russell Sage Foundation, 1955.

5. Gregg, Dorothy E. "The Psychiatric Nurses' Role", American Journal of Nursing, 54:848-851.

6. Hofling, Charles K. and Leininger, Madeleine M. Basic Psychiatric Concepts in Nursing, Philadelphia: J. B. Lippincott Co., 1960.

7. Hyde, Robert W. Experiencing the Patient's Day, New York: G. P. Putnam's Sons, 1955.

8. Local Hospital Compendium of Ethical Responsibilities

9. Peplau, Hildegard E. "Therapeutic Concepts, Aspects of Psychiatric Nursing", League Exchange, No. 26, Section B, New York: National League for Nursing.

10. Robinson, Alice M., The Psychiatric Aide: A Textbook for Patient Care, 2nd ed., Philadelphia: J. B. Lippincott Co., 1959.

Content	Learning Experiences and Methods
II. GROWTH AND DEVELOPMENT	
A. NEEDS OF THE HUMAN ORGANISM	Lecture and discussion
1. Definition of need	
2. Physiological needs	
a. food, shelter, clothing	
b. exercise and rest	
3. Safety needs	
a. protection from physical injury	
b. protection from emotional trauma	
4. Belonging and love needs	Ward conference: Identification of ward personnel as groups having specific needs
a. group participation	
b. trust in others	
c. manifestations of belonging	
5. Self esteem needs	Assignment:
a. maintenance of prestige and status	1) Assess some of the needs of selected patients on assigned wards
b. threats to prestige	
c. recognition and approval	
6. Self realization needs	2) Identify opportunities for creativity of personnel and patients within the hospital
a. opportunity for creativity	
b. integrity and dignity	
B. THE CONCEPT OF ANXIETY	Lecture and discussion
1. Definitions	
a. anxiety	
b. fear	
2. Sources	
a. internal	
b. external	
3. Symptoms	
a. physiological	
b. psychological	

Contents	Learning Experiences and Methods
4. Reactions to anxiety	
a. positive	
b. negative	
5. Relationship to need satisfaction	
C. THE STAGES OF GROWTH	
1. The prenatal period	Lecture and discussion
a. value of prenatal care	
b. emotional state of the mother	
2. Infant - birth to one year	
a. physical growth	Lecture and discussion
b. emotional development	
c. social behavior	
d. specific needs of infancy	
3. Early childhood - 1 to 5 years	
a. physical growth	
b. emotional development	
c. social behavior	Assignment:
d. specific needs of early childhood	Oral reports on assigned reading
4. Later childhood - 6 to 12 years	material
a. physical growth	
b. emotional development	
c. social behavior	
d. specific needs of later childhood	
5. Adolescence - 13 to 20 years	
a. physical growth	
b. emotional development	
c. social behavior	
d. specific needs of adolescence	
6. Adulthood - 21 to 65 years	
a. maturity	
1. physical aspects	
2. emotional aspects	
3. social aspects	

Content	Learning Experiences and Methods
b. cultural expectations of the mature adult 1. selection of marriage partner 2. marriage 3. family relationships 4. earning a living 5. recreation 6. retirement c. cultural differences	
7. The aging process - 65 years plus a. physical changes b. specific needs c. population trends d. specific problems 1. nursing homes 2. state hospital care 3. Social Security Act	Lecture and discussion Tour: Geriatric area of state hospital and discuss reactions Ward conference: Identification of various attitudes of society toward the aging population
D. PERSONALITY 1. Definition 2. Types 3. Structure and/or functions of a. basic energy drives b. reasoning c. conscience	Lecture and discussion
4. Factors which influence personality a. heredity b. environment c. social conditions d. cultural forces 5. Methods of adjustment a. mental mechanisms 1. purpose 2. definition 3. manifestation b. symptom formation	Assignment: A Healthy Personality for your Child Ward conference: Identification of factors which may have contributed to the personality type and/or to the illness of a selected patient

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A. Books, Pamphlets, Mimeographed Materials

1. Children's Bureau Publications, U.S. Dept. of Health, Education and Welfare
   Infant Care No. 8., 1955
   Your Child from Six to Twelve
   The Adolescent in Your Family
   A Healthy Personality for Your Child

2. Science Research Associates, Inc., 57 W. Grand Ave., Chicago, Ill.
   The SRA Better Living Booklets: Ross, Helen, Fears of Children

   English, O. Spurgeon and Finch, Stuart M., Emotional Problems of Growing Up.

   Menninger, Wm. C., Self Understanding - A First Step to Understanding Children.

3. Strecker, Edward A., and Appel, Kenneth E., Discovering Ourselves, 3rd ed., New York: The MacMillan Co., 1960.

B. Films:
(Michigan Department of Mental Health, Education Section
Film Series on Growth and Development)

Terrible Two's and Trusting Three's
Frustrating Four's and Fascinating Five's
From Sociable Six to Noisy Nine
From Ten to Twelve
The Inner Man Steps Out
Preface to a Life
The Steps of Age

Content	Learning Experience and Methods
III. SIGNS AND SYMPTOMS OF MENTAL ILLNESS	Lecture and discussion
A. FORMATION OF SYMPTOMS 1. Failure of psychological defense mechanisms in conflict 2. Conflict a. concept b. types of conflict	Assignment: Noyes, Modern Clinical Psychiatry Ward conference: Identification of examples of conflict as seen in patients, personnel and society
B. CAUSE AND MEANING OF SYMPTOMS 1. Psysiological 2. Psychological	Ward conference: Identification of mechanisms used in various stress situations
C. AREAS OF DISTURBED FUNCTIONING 1. Thinking a. disorders of perception b. disorders of orientation c. disorders of memory d. disorders of thought progression and content 2. Somatic a. motor activity b. psychophysiological disturbances 3. Affect	Assignment: Observe and analyze one incident involving assigned patient in terms of cause of behavior and meaning for the patient, and implications for nursing care Ward conference: Recognition of symptoms observed in patients
D. SYMPTOMS COMMONLY OBSERVED 1. Anxiety 2. Depression 3. Obsession, compulsions 4. Hallucinations, delusions 5. Withdrawal 6. Hostility	

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A. Books, Pamphlets, Mimeographed Materials

1. Mimeographed sheets of signs and symptoms of mental illness.

2. Brown, Amy and Fowler, Grace. Psychodynamic Nursing, Philadelphia: W. B. Saunders Co., 1960.

3. Kalkman, Marion E. Introduction to Psychiatric Nursing, New York: McGraw-Hill Book Co., 1958.

4. Noyes, Arthur P. and Kolb, Lawrence C. Modern Clinical Psychiatry, 5th ed., Philadelphia: W. B. Saunders Co., 1958.

5. Noyes, Arthur P., Haydon, Edith M., and VanSickel, Mildred. Textbook of Psychiatric Nursing, 5th ed., New York: McMillan, 1957.

6. Matheney, Ruth V. and Topalis, Mary. Psychiatric Nursing, St. Louis: The C. V. Mosby Co., 1961.

7. Robinson, Alice, M. The Psychiatric Aide: A Textbook for Patient Care, Philadelphia: J. B. Lippincott Co., 1959.

8. Weiss, Madeline O., Attitudes in Psychiatric Nursing Care, New York: G. P. Putnam's Sons, 1954.

9. Toward Therapeutic Care. Group for the Advancement of Psychiatry, Committee on Psychiatric Nursing. No. 51. New York: 1961.

B. Films:
(Michigan Department of Mental Health, Education Section.)

- Angry Boy
- Breakdown

Content	Learning Experiences and Methods
IV. DEVIATE PATTERNS OF BEHAVIOR	
A. WITHDRAWAL PATTERN OF BEHAVIOR	Lecture and discussion
1. Dynamics of withdrawal	
2. Recognition of withdrawal	Reference assignment
3. Nursing care	
a. problems	Ward conference: Discussion of specific patient showing pattern of withdrawal.
b. approaches	
c. nurse-patient relationship	
d. group relationships	
B. AGGRESSIVE PATTERN OF BEHAVIOR	Lecture and discussion
1. Dynamics of aggressive and assultive behavior	
2. Recognition of aggressive behavior	Ward conference: Discussion of specific aggressive patient using assultive behavior
3. Fear - major factor in assultive behavior	
4. Nursing care	
a. problems	
b. approaches	
c. nurse-patient relationship	
d. group relationships	
C. DEPRESSIVE PATTERN OF BEHAVIOR	Lecture and discussion
1. Dynamics of depression	
2. Recognition of depression	Ward conference: Discussion of depressed patient
3. Nursing care	
a. problems	
b. approaches	
c. nurse-patient relationships	
d. remotivation of patient	
e. group relationships	
f. recognition of suicidal intentions	
g. precautions against suicide	

Content	Learning Experiences and Methods
D. PROJECTIVE PATTERN OF BEHAVIOR	Lecture and discussion
1. Dynamics of projective pattern	
2. Recognition of projection	
3. Use of projection in the paranoid process	
a. problems	Ward conference: Discussion of specific
b. approaches	patient using projective pattern
c. nurse-patient relationship	
d. group relationships	Reference assignment
E. ANXIETY PATTERN OF BEHAVIOR	Lecture and discussion
1. Dynamics of anxiety	
2. Recognition of behavior due to anxiety	Ward conference: Discussion of specific
3. Nursing care	patient using physical symptoms or
a. problems	ritualistic behavior to handle anxiety
b. approaches	
c. nurse-patient relationship	Reference assignment
d. group relationships	
F. SOCIALLY AGGRESSIVE PATTERNS OF BEHAVIOR	Lecture and discussion
1. Dynamics of anti-social behavior	
2. Recognition of anti-social behavior	Ward conference: Discussion of specific
3. Nursing care	patient with socially aggressive
a. problems	behavior
b. approaches	
c. nurse-patient relationship	Reference assignment
d. group relationships	
G. PATTERN OF BEHAVIORAL OR PATIENT DEPENDENT ON ALCOHOL OR DRUGS	Lecture and discussion
1. Dynamics of dependency	Ward conference: Discussion of specific
2. Recognition of dependency	alcoholic patient or patient addicted
3. Brain syndrome	to use of drugs

Content	Learning Experiences and Methods
a. acute b. chornic 4. Nursing care a. problems b. approaches c. nurse-patient relationship d. group relationships	
H. ORGANIC BEHAVIOR DISORDERS 1. Brain syndromes a. causes b. characteristics 1. acute 2. chronic 2. Recognition of behavior changes 3. Nursing care a. problems b. approaches c. nurse-patient relationship d. group relaticnships	Lecture and discussion Ward conferences: Discussion of specific patient with illness due to organic disease

Content	Learning Experiences and Methods
V. EPILEPSY	
A. DEFINITION	
B. TYPES OF EPILEPTIC SEIZURES 1. Grand Mal 2. Petit Mal 3. Psychomotor 4. Jacksonian	
C. DIAGNOSTIC AIDS 1. Medical and family history 2. Neurological and physical examination 3. Laboratory studies 4. Psychometric examination and interview 5. Nursing observations 6. Induced seizures	Lectur and discussion Reference assignment
D. TREATMENT 1. Medical 2. Psychological 3. Surgical	
E. NURSING CARE 1. Problems 2. Approaches 3. Nurse-patient relationships 4. Group relationships	

Form Used At

STATE HOSPITAL FOR EPILEPTICS

#257

Patient's Name _____ No. _____

Date _____ Time _____

Did patient ever state that she had any aura or forewarning?

_____

If so, what was the nature of it? (Describe in patient's own words on reverse side of paper) Time of aura before seizure

_____

_____

Characterization of seizure: (Check)

Did patient cry out? _____

Fall? _____ Right _____ Left _____

Pitch _____ Collapse _____

Tonic (Stiffening) phase present _____

What parts of body first affected? _____

What parts of body affected? _____

_____

Did all affected parts of body seem to shake with equal intensity? _____

Length of clonic phase _____

Eyes rolled? _____ Right _____ Left _____

Continuous _____ Transient _____

Face turned? _____ Right _____ Left _____

Continuous _____ Transient _____

Head turned? _____ Right _____ Left _____

Did patient bite tongue? _____

Did patient lose bladder control? _____

Did patient lose bowel control? _____

Did patient lose consciousness? _____

Did patient sleep following seizure? _____

Did patient become disturbed following seizure? _____

Length of entire seizure? _____

Reported by _____

For additional remarks use reverse side of paper.

TEACHING AIDS

A. Books, Pamphlets, Mimeographed Materials

1. Crawford, Annie L., and Buchanan, Barbara B., Psychiatric Nursing, Philadelphia: F. A. Davis Co., 1961.

2. Gibbs, Frederick A., and Stamps, Frederick W., Epilepsy Handbook, Springfield, Illinois: Charles C. Thomas, 1958.

3. Matheney, Ruth V., and Topalis, Mary, Psychiatric Nursing, St. Louis: C. V. Mosby Co., 1961.

4. Noyes, Arthur P., and Kolb, Lawrence C., Modern Clinical Psychiatry, 5th ed., Philadelphia: W. B. Saunders Co., 1958.

5. Steele, Katherine and Manfreda, Marguerite L., Psychiatric Nursing, 6th ed., Philadelphia: F. A. Davis Co., 1961.

6. Von Mering, Otto and King, S. H., Remotivating the Mental Patient, New York: Russell Sage Foundation, 1957.

7. Toward Therapeutic Care. Group for the Advancement of Psychiatry, Committee on Psychiatric Nursing. No. 51, New York: 1961.

B. Films:
Michigan Department of Mental Health, Education Section.

Alcoholism: The Revolving Door
Feelings of Hostility
Overdependency
Retire to Life
The Proud Years

Smith, Kline and French Laboratories: Philadelphia

Psychiatric Nursing: The Nurse-Patient Relationship

United World Film, Inc.: New York

Seizure

Ayerst Laboratories: Chicago

Modern Concepts of Epilepsy

Content	Learning Experiences and Methods
VI. MENTAL RETARDATION	
A. INTRODUCTION	
1. Historical concepts	Lecture and discussion
2. Definition	
3. Social Attitudes	Reference assignment
a. problems related to family	
b. community attitudes and their influence	
B. CAUSES	
1. Prenatal	
a. genetic	
1. chromosome defects	
2. metabolic defects	
3. Rh factor incompatibility	
b. gestational	
1. infections	
2. nutritional deficiencies	
3. prematurity	
2. Peri-natal	
a. trauma	
b. cerebral anoxia	
3. Post-natal	
a. central nervous system infections	
b. trauma	
c. anoxia	
d. lead ingestion	
C. CLASSIFICATIONS OF MENTAL RETARDATION	Lecture and discussion
1. Mildly retarded (50-70 I.Q.)	
a. where cared for	Reference assignment
b. levels of competence	
c. goals of training program	
d. special problems	

Content	Learning Experiences and Methods
2. Moderately retarded (30-50 I.Q.) a. where cared for b. levels of competence c. goals of training program d. special problems 3. Severely retarded (0-30 I.Q.) a. where cared for b. levels of competence c. goals of training program d. special problems	
D. COMMONLY SEEN ENTITIES 1. Cerebral malformations a. microcephaly b. macrocephaly c. hydrocephaly 2. Mongolism 3. Brain damaged 4. Metabolic disturbances 5. Familial disorder	Lecture and discussion Reference assignment Ward conference: Presentation of commonly seen entities
E. CONDITIONS ASSOCIATED WITH RETARDATION 1. Sensory impairment 2. Motor defects 3. Structural abnormalities 4. Language disorders 5. Psychological disturbances	Lecture and discussion Reference assignment
F. TREATMENT 1. Medical 2. Education and Training	

Content	Learning Experiences and Methods
G. NURSING CARE 1. Goals in care of patient 2. Training in activities of daily living 3. Needs of the patient a. psychological 1. security, recognition, dependency, support, redirection, affection 2. influence of attitudes on patient b. physical 1. principles of good health and hygiene 2. care of physical illness or abnormality c. social 1. group living 2. relationship with families, peers and employees	
H. INTERDISCIPLINARY APPROACH 1. Diversity of needs of mentally retarded patient 2. Roles of disciplines 3. Community involvement	Lecture and discussion Reference assignment
I. PREVENTION OF MENTAL RETARDATION 1. Improved prenatal care 2. Early diagnosis and treatment 3. Research	

TEACHING AIDS

A. Books, Pamphlets and Mimeographed Materials

1. American Journal of Mental Deficiency. A bi-monthly publication by the American Association on Mental Deficiency.

2. Anatomical Charts.

3. Buck, Pearl. The Child Who Never Grew, New York: The John Day Co., 1950.

4. Chamberlain, Naomi H. and Moss, Dorothy H. The Three R's for the Retarded, New York: The National Association for Retarded Children.

5. Davies, Stanley P. The Mentally Retarded in Society, New York: Columbia University Press, 1962.

6. Dittman, Laura. The Mentally Retarded Child at Home, Washington, D. C.: Children's Bureau, Publication No. 374, U.S. Dept. of Health, Education and Welfare, 1959.

7. Home Care of the Mentally Retarded Child, 3rd printing, Vineland, New Jersey: prepared by the staff of the training school at Vineland, New Jersey, 1961.

8. Hutt, Max L. and Gibby, Robert G. The Mentally Retarded Child, Boston: Allyn & Bacon, Inc., 1958.

9. Kirk, Samuel, Karnes, Merle B. and Kirk, Winifred D. You and Your Retarded Child, New York: The MacMillan Co., 1958.

10. Levinson, Abraham. The Mentally Retarded Child, New York: The John Day Co., 1952.

11. Michal-Smith, Harold. The Mentally Retarded Patient, Philadelphia: J. B. Lippincott Co., 1956.

12. Sarason, Seymour. Psychological Problems in Mental Deficiency, New York: Harper and Bros., 1959.

13. The Backward Child, Mental Health Division - Department of National Health and Welfare: Ottawa, Canada, 1957.

14. The Child Who is Mentally Retarded, Children's Bureau Folder No. 43, Washington, D. C.: U.S. Department of Health, Education and Welfare, 1956.

15. Tregold, Alfred Francis and Soddy, Kenneth. A Textbook of Mental Deficiency, 9th ed., London: Bailliere, Tindall & Co., 1956.

16. Wallin, John Edward. Children with Mental and Physical Handicaps, New York: Prentice Hall, Inc., 1949.

B. Films:
Michigan Department of Mental Health, Education Section

A Class for Tommy

Tuesday's Child

Content	Learning Experiences and Methods
VII. CLASSIFICATION OF MENTAL ILLNESSES	
A. DISORDERS CAUSED BY IMPAIRMENT OF BRAIN TISSUE FUNCTION	Lecture and discussion
B. PSYCHOTIC DISORDERS 1. Involutional psychotic reaction 2. Affective reactions 3. Schizophrenic reactions 4. Paranoid reactions	Reference assignment
C. PSYCHOSOMATIC DISORDERS	
D. PSYCHONEUROTIC DISORDERS 1. Anxiety reaction 2. Dissociative reaction 3. Conversion reaction 4. Phobic reaction 5. Obsessive compulsive reaction 6. Depressive reaction 7. Others	
E. CHARACTER DISORDERS	
F. BEHAVIOR DISORDERS OF CHILDREN	

Contents	Learning Experiences and Methods
VIII. THERAPIES	
A. SOMATIC THERAPIES	
1. Electroconvulsive therapy	
2. Insulin coma therapy	Lecture and discussion
3. Other coma therapies	
4. Psychosurgery	Ward conference: Observation and participation in administration of somatic therapies
5. Hydrotherapy	
6. Nursing Care	
B. PSYCHOTHERAPY	
1. Individual therapy	
2. Group	Reference assignment
3. Nurse's supportive role	
C. CHEMOTHERAPY	
1. Tranquilizing drugs	
2. Psychic energizers	
3. Nursing care in chemotherapy	
D. OTHER THERAPIES	

TEACHING AIDS

A. Books, Pamphlets, Mimeographed Materials

1. Kalkman, Marion E. Introduction to Psychiatric Nursing, New York: McGraw-Hill Book Co., 1958.

2. Matheney, Ruth V. and Topalis, Mary. Psychiatric Nursing, 3rd ed., St. Louis: C. V. Mosby Co., 1961.

3. Mimeographed sheets: Nursing Care of Somatic Procedures
   Recreational Activities for Ward Use
   Suggestions for Planning Ward Activities Program
   Tranquilizing Drugs

Content	Learning Experiences and Methods
IX. REHABILITATION	
A. DEFINITION	
B. GOALS OF REHABILITATION	Lecture and discussion
C. REHABILITATIVE HOSPITAL SOCIAL STRUCTURE	Ward conference: Observation of patient participation in Patients' Council, RT, OT
D. UNIT OF REHABILITATION	
E. REHABILITATIVE ATTITUDES IN PERSONNEL	
F. PROCESS OF REHABILITATION 1. Determination of existing ability of patient 2. Development of experiences appropriate to current level of functioning 3. Involvement of patient, family and community in process of rehabilitation	Reference assignment
G. ROLE OF THE NURSE	Field trips-nursing homes, family care homes, half-way house, consultation center or public health agency

TEACHING AIDS

A. Books, Pamphlets and Mimeographed Materials

1. Schwartz, Morris and Schockley, Emery L. The Nurse and the Mental Patient, New York: Russell Sage Foundation, 1956.

2. Ingram, Madeline Elliott, Principles and Techniques of Psychiatric Nursing, 5th ed., Philadelphia: W. B. Saunders Co., 1960.

3. Von Mering, Otto and King, S. H. Remotivating the Mental Patient, New York: Russell Sage Foundation, 1957.

4. Robinson, Alice M. The Psychiatric Aide: A Textbook for Patient Care, 2nd ed., Philadelphia: J. B. Lippincott Co., 1959.

B. Films:
Michigan Department of Mental Health, Education Section

Bitter Welcome
Man to Man
Psychiatry in Action
Retire to Life
RX Attitudes

Content	Learning Experiences and Methods
X. LEGAL ASPECTS OF NURSING CARE	
A. TERMINOLOGY 1. Legal 2. Psychiatric	Lecture and discussion
B. COMMITMENT LAWS 1. General 2. Michigan	Assignment: Review sample of a court order
C. ATTENDANT NURSE'S RESPONSIBILITIES 1. Patient's legal rights a. transaction of business with an outsider b. communication 1. telephone calls 2. letters 3. wills 2. Criminal offenses a. negligence b. assult and battery c. defamation d. carnal knowledge of a patient 3. Nursing situations with potential legal involvement a. admission procedure b. transfer procedure c. discharge d. restraint e. medication 1. narcotics 2. recording 4. Special situations with potential legal involvement	Field trip: Visit Probate Court

TEACHING AIDS

A. Books, Pamphlets and Mimeographed Materials

1. Davidson, Henry A. Forensic Psychiatry, New York: The Ronald Press Company, 1952.

2. Lesnik, Milton J. and Anderson, Bernice. Nursing Practice and the Law, Philadelphia: J. B. Lippincott Company, 1962.

3. Mereness, Dorothy and Kornosh, Louis. Essentials of Psychiatric Nursing, 6th ed., St. Louis: The C. V. Mosby Company, 1962.

4. Department of Mental Health. Michigan Department of Mental Health Statutes (12-1-60), Lansing: 1961.

5. Noyes, Arthur, Hayden, Edith and Van Sickel, Mildred. Textbook of Psychiatric Nursing, 5th ed., New York: The MacMillan Company, 1958.

6. Recommendations for Probate Court Practice. Prepared by A Group of Southeastern Michigan Probate Judges, Hon. John W. Conlin, Chairman. Lansing: Office of the Court Administrator.