A SURVEY OF THE

WAYNE COUNTY

TRAINING SCHOOL

NORTHVILLE, MICHIGAN

SUBMITTED BY THE:

AMERICAN PSYCHIATRIC ASSOCIATION

1961

American Psychiatric Association

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Pasquale Buoniconto, M.D.
Medical Superintendent
Wayne County Training School
Northville, Michigan

Dear Doctor Buoniconto:

I have the honor to present the report of the Survey of the Wayne County Training School prepared under my direction by a distinguished Committee and its consultants, ably chaired by Dr. George Tarjan. I share the Committee's belief that this report together with that of the Central Inspection Board of the American Psychiatric Association, submitted earlier from my office, constitute a practical, forward-looking approach.

Respectfully yours,

Mathew Ross

MATHEW ROSS, M.D.
Medical Director

MR:vg

SURVEY OF

THE WAYNE COUNTY TRAINING SCHOOL

Presented to

Pasquale Buoniconto, M. D.
Medical Superintendent
Wayne County Training School
Northville, Michigan

by

Mathew Ross, M. D.
Medical Director
American Psychiatric Association
April 1961

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CHAPTER I

INTRODUCTION

This document summarizes the observations, opinions, and recommendations of the Wayne County Training School Survey Committee appointed by Dr. Mathew Ross, Medical Director of the American Psychiatric Association.

The members were:

Dr. Charles K. Bush
Dr. Leonard J. Duhl
Dr. Benedict Nagler
Dr. Mathew Ross
Dr. George Tarjan, Chairman

Consultants to the Committee were:

Mr. Estel E. Black
Mr. Sheldon J. Brown
Mr. Robert W. Hayes
Mr. Charles V. Keeran

A brief summary of the major recommendations is presented first, followed by a description of the survey. The observations are grouped into two chapters: those which concern the operations of the Wayne County Training School directly, and those which pertain to the Wayne County community in general. A set of basic assumptions precedes the specific recommendations to provide a frame of reference for the reader.

Brief biographical sketches of the Committee members and the consultants are given in Appendix A. Appendix B lists the individuals who contributed information. The Survey Committee wishes to express its appreciation to them for their assistance.

It is hoped that the findings and recommendations will assist the Administrative Board of the Training School and the Wayne County Board of Supervisors in planning for the future of the facility.

C. EXTRAMURAL AND PART-HOSPITALIZATION PROGRAMS

5. Develop partial hospitalization and extramural programs. They should replace residential treatment whenever possible, and should include:

   a. Outpatient diagnostic and treatment services.

   b. Day and night hospital treatment programs.

   c. Aftercare clinic services for released patients.

   d. A foster home placement program.

   e. Sheltered workshops and vocational placement opportunities for residential or extramural patients.

D. COMMUNITY SERVICES

6. Assume leadership in broad planning and coordination of county programs in the field of retardation, specifically:

   a. Integrate programs of the Training School with services performed by health, education, welfare, judicial, and other agencies.

   b. Evaluate, on a continuous basis, the services necessary to meet the needs of the retarded in Wayne County.

   c. Maintain close liaison with community agencies which deal with the problems of mental retardation.

   d. Provide consultation to community agencies and practitioners regarding individual patients.

E. RESEARCH AND TRAINING

7. Intensify research and professional training activities by:

   a. Encouraging all staff members, particularly of the treatment disciplines, to participate.

   b. Emphasizing collaborative programs with nearby universities and facilities of the State Department of Mental Health.

   c. Stimulating qualified members of the professional staff to seek university appointments, and giving them an opportunity to carry out the acquired obligations.

F. PERSONNEL REQUIREMENTS

8. Augment the treatment staff in accordance with the recommended expansion of services. The most urgent needs are:

   a. Reinforcement of the psychiatric staff.

   b. Enlargement of the Social Work Department, with emphasis on full professional training.

   c. Strengthening of the psychiatric nursing staff and their role in the general care of patients.

   d. Organization of a volunteer program.

9. Integrate the patients' daily treatment program by:

   a. Assigning the primary responsibility for the treatment of patients to psychiatrists.

   b. Providing each psychiatrist with a clinical team.

10. Intensify the training program for nursing and cottage life personnel.

11. Authorize the filling of vacant positions without need for re-justification.

12. Provide, within the provisions of the merit system, sufficient flexibility to allow staffing patterns to be altered in accordance with changing program needs.

G. ADMINISTRATIVE, ORGANIZATIONAL, AND FISCAL CONCERNS

13. Establish a Professional Advisory Committee with representatives from universities and the various treatment disciplines.

14. Provide added support for the Medical Superintendent through the establishment of three major assistant administrative positions. They are:

    a. An assistant medical administrator in charge of treatment activities. The community services unit could also be under his supervision.

    b. An assistant medical administrator in charge of the research and professional training functions.

    c. A business administrator in charge of fiscal, personnel, and service operations.

15. Implement recommendations contained in previous reports by the Central Inspection Board of the American Psychiatric Association.

16. Re-evaluate the therapeutic and fiscal contributions of some traditional activities such as the farm and dairy.

17. Explore further the possibility of obtaining additional fiscal resources such as:

    a. Larger reimbursements from the State Department of Mental Health.

b. Subsidies from the State Department of Education, and local school districts.

c. Support from granting agencies, especially for the research and training programs.

18. Consider changing the name of the institution to more closely reflect the new treatment orientation suggested.

CHAPTER III

THE SURVEY

A. REASONS

The Wayne County Training School was founded in 1925 to meet clearly defined therapeutic, educational, and social needs of the mildly retarded youth of Wayne County, Michigan. The Training School received widespread recognition in the field of retardation for its program.

During ensuing years, particularly in the 1950's, additional services for the retarded were developed in the communities. The growth of special education, with classes for the retarded in public schools, should be specifically noted. In light of new services, with increasing frequency the question was raised whether there was a need for the Training School to continue in its traditional role.

County revenues were adequate to meet general expenditures during World War II and the years that followed. In recent years, however, growing difficulties were encountered in balancing revenues and expenditures. Officials and other significant groups felt a need to re-evaluate several county operations, including the Training School. Many pointed and pertinent questions were raised and a number of controversial solutions were proposed.

Three basic questions became generic to most issues under discussion:

1. Should the Training School be continued with its present or a modified program, in spite of its cost to the local taxpayers?

2. Could an alternate plan be found which would eliminate the cost, at least in part, and still assure reasonable services to the retarded youth of Wayne County?

3. As a corollary to question 2, it was proposed that the Training School be turned over to Michigan's State Department of Mental Health, which would relieve the county of its special tax burden, and place services for its retarded youth on a par with those of the rest of the state.

To solve this dilemma between concern for high-level services and the need for economy, the Administrative Board of the Training School requested a survey, to be conducted by an impartial professional group. It was expected that their report would assist the Administrative Board and the Board of Supervisors in their final decision.

B. ARRANGEMENTS

The survey was financed by the McGregor Fund of Detroit. With the approval of the Board of Supervisors, the Administrative Board of the Training School requested the Medical Director of the American Psychiatric Association, Dr. Mathew Ross, to conduct the study. Dr. Ross appointed a committee composed of five Fellows of the Association. Recognizing the complex clinical and administrative issues involved, the advice of special consultants was obtained.

The letter requesting the survey stated that the responsible groups of Wayne County were ". . .particularly interested in having an impartial outside group review specifically what the needs of the County of Wayne are in regard to its mentally retarded. They wish to know what agencies are meeting these needs and whether or not the Training School is filling the void in services which cannot be met by any presently existing agencies, either in the county or the State of Michigan. These bodies are also concerned in what direction, if any, expansion of the existing programs at the Training School should take. The Survey Team would also explore any other matters that might be pertinent, either in the field of the mentally retarded, or the youth of Wayne County."

C. METHODOLOGY

In view of limitations imposed by distance, time, and financial resources, the Committee decided on three approaches:

1. Collection of information from available resource materials and through correspondence with individuals representing significant groups

Available resource material included historical reports; operational data; annual reports; publications by the Training School staff; demographic, economic, social, and political information pertaining to Wayne County; listings of welfare and health resources relevant to programs for youth; and the reports of the Central Inspection Board of the American Psychiatric Association for 1957 and 1960. Through Dr. Pasquale Buoniconto, Medical Superintendent of the Wayne County Training School, representatives from different segments of Wayne County were invited to furnish the Committee with preliminary written opinions focused on four basic questions:

a. The unmet needs of Wayne County youth between 16 and 21 years of age, with strong and special reference to the mentally retarded.

b. Wayne County Training School presently serves the needs of mildly retarded adolescents of Wayne County. Should the School continue to do so, or are there other needs of Wayne County youth for which the facilities could be more effectively utilized?

c. Should, therefore, the program of Wayne County Training School be changed to adjust to newly identified unmet needs of the county's youth, or should it remain unchanged and/or be expanded along present lines?

d. A general evaluation of the program, without specifics to facilities.

The Committee received and reviewed over thirty preliminary statements. The overwhelming majority were supportive of the program; however, a number of changes were suggested for the future.

2. Site Visit

Members of the Committee and the consultants visited the Wayne County Training School on November 16 and 17, 1960. They discussed past, current, and planned programs with the staff, and viewed the operation. Two consultants also visited one of the state institutions for the mentally retarded to obtain some comparative information between types of children served, facilities available, and programs in operation in the two institutions.

3. Discussions with individuals acquainted with the problems of Wayne County youth and of the Training School

On November 16, 17, and 18 the Committee met with community representatives who generously gave of their time and shared their experiences and opinions. The discussions were conducted in an informal fashion so that the statements of one could easily stimulate another in expressing supportive or contrary opinions.

At the onset it was planned to focus on the questions outlined in the original communication to the Medical Director of the American Psychiatric Association. It became evident that a core issue was the possible transfer of the Training School to the State Department of Mental Health.

In view of the recent survey by the Central Inspection Board of the APA, it was decided to restrict inquiries in those areas which were covered in detail in the CIB report submitted separately to the administration of the Training School.

CHAPTER IV

THE WAYNE COUNTY TRAINING SCHOOL*

A. HISTORY

In 1919 only 111 out of 568 children recommended for commitment from Wayne County had been admitted to Lapeer State Home and Training School; the others remained in the community awaiting a vacancy. It became apparent that many mentally retarded children, needing residential care, were not accomodated. The Board of Supervisors decided to establish a county-operated training school.

The Board sought enabling legislation and in 1921 Act 392 of the Public Acts was passed by the state legislature. It provided that any county in the state could, by resolution of its Board of Supervisors, provide for the care, custody, and maintenance of feebleminded persons within such county. The counties were authorized to enact measures for the needed revenue. Wayne County voters passed the necessary bond issues to acquire the land and build facilities.

In 1925 an ordinance was passed which became the legal basis for operation of the Training School. In 1926 the first pupils were admitted on transfer from the Lapeer State Home and Training School.

It should be noted that 35 years have passed since the enactment of the Wayne County ordinance, yet no other counties have established similar programs, nor have they sought a contractual arrangement with Wayne County for the services offered at the Training School.

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*Data contained in this chapter were obtained from a number of sources. A most diligent attempt was made to reconcile discrepancies in the information available.

The original aims of the institution and the enthusiastic expectations of the public are reflected in statements of the Chairman of the Ways and Means Committee of the Board of Supervisors, who said in 1925:

> ". . . this is by far the most pretentious undertaking ever attempted by the County of Wayne; through its agency many persons are to be reclaimed to become useful and respected citizens. . .
>
> "The purpose of the establishment of the Training School. . . was to attempt to increase, if possible, salvage among the higher grade mentally deficient children in the County.
>
> "The children the Training School was to receive were children who had already developed serious and crippling characterial deviations: some of these deviations in the direction of resignation to abject failure; others in the direction of threatening aggressiveness. The problem set was twofold: first to attempt to uncover the nature of remedial factors, if possible, at the bottom of such deviations from normal development of workable character and second to create a program that would help the child to rehabilitate himself. . ."*

From the beginning the School was a patient-centered facility, utilizing medical, educational, psychological, vocational, and social work techniques to understand and treat its mildly retarded patients. Considerable emphasis was placed on research and staff development. Much effort was exerted to develop more effective ways of motivating students toward modifying their unacceptable behavior and toward achieving maximum performance. Considered against the backdrop of institutional treatment of the 1920's, these were clearly progressive concepts.

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*Hegge, Thorleif G.: Introduction, "Children with Mental and Emotional Disabilities." A Symposium held in celebration of the 25th Anniversary of the Wayne County Training School. Am. J. Ment. Defic., 56:665, 1952.

A Medical Superintendent was appointed and the nucleus of other key personnel was rapidly assembled. They vigorously applied themselves to the task at hand. Historical documents refer to early struggles in getting new employees, with previous experience in mental institutions, to accept the Training School's "new approach." Within a few years its philosophy and program were firmly established. Stability became a tradition. Key employees worked together for many years. The original Medical Superintendent and the first Chief of Research served continuously until their retirement in 1955 and 1959, respectively.

B. LEGAL AND ADMINISTRATIVE FRAMEWORK

With minor amendments the original ordinance establishing the institution and its purposes has remained in effect.

The Training School is a separate operational entity of the county. It is controlled and managed by a 7-member Administrative Board, composed of: the Judge of Probate presiding for Wayne County; the County Superintendent, Wayne County Board of Education; the Superintendent of the Board of Education of the City of Detroit; and four residents of Wayne County, elected by the Board of Supervisors for overlapping terms of four years. The Administrative Board reports to the County Board of Supervisors who also elect, from among their members, a standing "Training School Committee" which serves as liaison between the Administrative Board and the 115 members of the Board of Supervisors.

The legislative and executive framework of Wayne County should be described briefly because of its effect on the Training School. The county has no chief administrative or executive officer. The Board of Supervisors is a unicameral body, nearly as large as the combined houses of the Michigan State Legislature. Its unusual size is due to laws which provide that newly incorporated townships must be represented, and the the City of Detroit must always maintain a majority. In such framework, administrative or managerial decisions often require considerable time.

The Administrative Board of the Training School appoints the Medical Superintendent, who serves as the Board's Secretary.

He appoints an Assistant Superintendent and a Business Manager with the approval of the Administrative Board, and as many other employees deemed necessary by the Board. All appointments must be made in accordance with the rules and regulations of the County Civil Service Commission.

The Medical Superintendent is responsible for implementation of the Board's policies; for program coordination and evaluation; and for recommendations on planning. He is also the chief representative of the Training School to other county agencies and the public at large. The support and advice of executives of similar agencies, or of a "central department," are not available to him. On the Administrative Board there are influential citizens and members of the legal and educational professions, but representatives of medicine, its specialties, and its allied fields are absent.

External demands on the Medical Superintendent become sizable, and these restrict the time available for internal affairs. He directly supervises some thirteen individuals and units, including such functions as fire and safety; payroll and personnel; clinical records; and the typist pool. His span of control should be limited to a few highly qualified assistant administrators. Some of the assistants are also hampered by extensive supervisory responsibilities. For instance, the business manager has nine persons reporting directly to him.

C. FISCAL STRUCTURE

The Training School submits its budget requests to the Board of Supervisors, which appropriates the funds. During the fiscal year ending November 30, 1959, the county budget exceeded 63 million dollars, while the Training School's was little more than $2,300,000--only 3.6% of the total.

Fiscal considerations were repeatedly emphasized during the survey and revolved around the ability of Wayne County to maintain a specialized program for its mentally retarded youth.

In Michigan the expense of caring for the mentally retarded in a public institution is divided between the state and the county. When a patient is in a state institution the county is billed for the cost of the first year of care. In 1959 the rate was $5.25 per day per patient. After the first year, the state assumes the full cost. The state reimburses Wayne County for patients in residence past the first year at an annually-determined rate ($4.30 per day in 1959). The difference between charges to the county and reimbursement to the Training School by the state was repeatedly questioned. The disparity may partially be explained by the higher cost of care for newly admitted patients.

Local school districts which establish special classes for the educable retarded receive excess subsidies from the state. The additional reimbursement can reach $410 per pupil per year (two units of ordinary subsidy) but cannot exceed 75% of the cost, or $6,150 per teacher.

Questions concerning the cost of the Training School more often pertained to specific public funds than expenditure of such funds in general. Four public resources were discussed in this respect:

1. The general funds of Wayne County

2. State funds, as appropriated through its Department of Mental Health

3. School district funds, and

4. State educational funds paid to local school districts

In light of these facts, the expenditures of Wayne County Training School were reviewed in approximate figures for the fiscal year ending November 30, 1959.

Appropriations were $2,346,000; expenditures, $2,072,000. Savings equalled 12%.

Revenues of the Training School came from two major sources:

State reimbursement for patients after the first year of residence, at $4.30 per day.	$874,000
Other revenues.	124,000
Total	$998,000

The net cost to the county was $1,074,000.

Had all "first-year" patients in the Training School been in one of the state institutions, the county would have been billed for $278,000. Deducting $278,000 from $1,074,000 results in a figure of $796,000, representing county expenditures which accrued because the patients received their treatment in the Training School, rather than at a state institution.

Arguments were advanced concerning additional revenues from such funds as local school districts within Wayne County, and state educational subsidies. Obtaining funds from these sources would require legislation, or administrative agreements between the public agencies involved.

Assuming that there were 400 patients at Wayne County Training School who otherwise would have been in classes for the educable within their home school district, and assuming that the cost per pupil had been $700 per year, this sum would have been divided as follows:

State subvention (400 x $410).	$164,000
Local school costs (400 x $390)	156,000
Total	$320,000

Were the Training School successful in obtaining such subsidies from the above two sources, the cost to the Wayne County general fund would decrease from $796,000 to $476,000.

Were the state reimbursement for patients, in residence over a year, raised from $4.30 to $5.25 per diem, even the $476,000 cost figure would decrease to below $200,000.

These facts are summarized to point out that latitude exists in administrative and fiscal negotiations. The concern of the Committee, however, was primarily with services needed by the patients. In this respect the gross per diem cost of $8.98* is not considered at all excessive. Larger appropriations could be used profitably to provide broader and more intensified treatment programs.

In recent years county-wide economy measures unfortunately necessitated the rejustification of vacant positions before new employees could be appointed, adding to the problems of recruitment and the maintenance of the budgeted level of services to the patients.

D. ADMISSION POLICIES AND PROCEDURES

Admission to the Training School is restricted to residents of the county. The Medical Superintendent can accept or reject any referral. Screening and processing of applications is done by the Director of Social Service. Guidelines for selection are:

1. The child must be between 6 and 15 years of age.

2. He or she must be educable; generally with a measurable IQ greater than 50.

3. He must be socially and occupationally trainable for independent living.

4. His behavior must be manageable at the Training School.

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*$180,000 charged against the Training School by the county for general staff services is prorated in calculating the $8.98 per diem cost.

Admissions are of two types:

1. Voluntary - The application is signed by the parent or legal guardian, and processed for financial investigation through the Collections Division of the Wayne County Department of Social Welfare. Approval is then obtained from the Judge of Probate.

2. Court Commitment - The family or other interested parties file a petition in the Probate Court to have the child declared mentally retarded. Two court-appointed physicians examine the child and submit their reports. The judge then commits the patient.

Upon receipt of the court commitment or properly cleared voluntary application, arrangements are made for admission by the Director of Social Service of the Training School.

In early days all admissions were on the basis of commitment; the recent trend favors voluntary admissions. In 1955 less than 10% of the admissions were voluntary. By 1960 the proportion rose to over 77%.

E. THE PATIENTS

1. The Resident Population

In numbers and certain characteristics the population of the Training School has not changed substantially over the years. The average census was 721 during 1949-50, and 688 during 1959-60. Boys have outnumbered girls by a ratio greater than two to one. The average age of those in residence has remained about the same. Girls have been generally somewhat older, the combined average age remained around 15.

Tables I, II, III, and IV describe the resident population of June 30, 1960 by sex, age, IQ, and other selected characteristics. Sixty-nine per cent were boys and 31% were girls. Seventy per cent came from Detroit,

and 30% from the out-county areas. Sixty-four per cent were Caucasian, and 36% belonged to other ethnic groups. There were very few (6%) under 10 years of age, and an even smaller number (4%) were over 21. As a group, the girls were more retarded than the boys.

Five per cent of all the patients had IQ's less than 50, an expected finding in an institution for the educable mentally retarded. Sixty-one per cent, however, had IQ's over 70. Opinions were repeatedly expressed that many in this group might not be considered mentally retarded by standards commonly used in state institutions.

This shift toward less retarded patients was considered of recent origin, coinciding with the trend for voluntary admissions.

A comparison between those who entered voluntarily and those who were committed was thought to shed some light on possible relationship. In Tables II, III, and IV, the patients in residence on June 30, 1960 were therefore compared in accordance with their type of admission. Some differences between voluntary and committed patients were noted but few were striking. Committed patients were generally older because a few years ago court proceedings were the primary means of admission, and because they probably stay longer. Younger, more recently admitted patients are more likely to have come on a voluntary basis. Sixty-nine per cent of the voluntary patients also had IQ's over 70, as contrasted with 53% of those committed. Committed patients more frequently came from foster settings or from the homes of relatives.

The two groups, on the other hand, did not differ in sex, racial belonging, or county area of residence. It may be concluded that most of the voluntary patients would probably have been committed had they not entered voluntarily.

These points are emphasized because concern was expressed that the Training School might be admitting

patients who would not qualify for admission to some other institutions for the retarded. The facts are that an increasing segment of the Training School patients are characterized by more severe emotional, behavioral, and sociological difficulties superimposed on a milder degree of intellectual impairment. All, however, were believed to be in need of residential care by the court, their guardians, and the specialists who examined them. Had they not been admitted to the Training School, they would have likely suffered from lack of other resources. They would have come to attention when their symptoms became more severe, or were altered to comply with the admission criteria of some public agency.

The shift in admission policies and in the composition of the patient population most likely was the result of changes in community needs and the Training School's response to them. This shift is probably the forerunner of a further similar trend.

The Training School chose to expand its program toward the less retarded adolescents with superimposed social, emotional, and behavioral handicaps. It could have concerned itself with other groups--the younger, the older, or the physically handicapped retarded. Staff interests and community needs undoubtedly influenced the decision.

TABLE I

Patient Population June 30, 1960

Status	Boys	Girls	Total
In residence	468	192	660
On the books away from WCTS	255	138	393
Total	723	330	1,053

TABLE II

Age Distribution of Patients in Residence
June 30, 1960 by Sex and Type of Admission

% in Specified Age Category					
Age Category	Boys	Girls	Total Resident Population	Type of Admission	
				Voluntary	Commitment
Under 10	6%	4%	6%	10%	1%
10 - 12	24	25	24	33	15
13 - 15	48	50	49	48	50
16 - 18	14	13	13	7	20
19 - 21	4	2	4	2	5
Over 21	4	6	4	0	9
Total	100%	100%	100%	100%	100%

TABLE III

IQ Distribution of Patients in Residence June 30, 1960
by Sex and Type of Admission

% in Specified IQ Category					
IQ Category	Boys	Girls	Total Resident Population	Type of Admission	
				Voluntary	Commitment
Below 50	3%	12%	5%	4%	7%
50 - 69	32	37	34	27	40
70 - 79	26	31	28	29	27
80 - 89	29	18	26	31	20
Over 90	10	2	7	9	6
Total	100%	100%	100%	100%	100%

TABLE IV

Resident Patients June 30, 1960 by Type of Admission

% in Specified Category			
Specified Category	Type of Admission		Total
	Voluntary	Commitment	
Boys	72%	66%	69%
Girls	28	34	31
Caucasian	63	64	64
Other	37	36	36
From Detroit	71	70	70
From "Out-county"	29	30	30
Home setting with at least one parent	87	67	77
Home setting with relative or foster parent	13	33	23

2. New Admissions

One hundred and ninety-three patients were admitted during 1959-60; 77% of them voluntarily. Seventy-five per cent came from the City of Detroit; the others, from the out-county areas.

Table V groups new patients by sex, age, and IQ. Girls, on the average, were somewhat older at the time of admission and more of them functioned with an IQ below 70. There has been little change in the mean age of new admissions during the last 30 years. The average has varied between 12 and 13 years.

The new patients came from a variety of home settings, were referred by a number of community agencies, and were admitted for several different reasons. These data are presented in Table VI.

3. Movement of Patients

From 1927 to 1960, 5,731 patients were admitted. The average daily population remained around 650. There were very few deaths. Beds were vacated by return of the patients to the community, or by an occasional elopement. The median length of stay has been about four years. The annual number of admissions approximates 25% of the available beds, representing a reasonable turnover for this type of program.

TABLE V

The 193 Patients Admitted During 1959-60
by Sex, Age, and IQ

	% in Specified Category		
Age Category	Boys (133)	Girls (60)	Total Admissions
Below 10	20%	10%	17%
10 - 11	25	23	24
12 - 13	33	25	31
14 - 15	22	42	28
Total	100%	100%	100%
IQ Category			
Below 49	0%	0%	0%
50 - 69	32	47	36
70 - 79	47	40	45
80 and over	21	13	19
Total	100%	100%	100%

TABLE VI

The 193 Patients Admitted During 1959-60
by Sex and Other Specified Characteristics

Category	% in Specified Category		
	Boys (133)	Girls (60)	Total Admissions (193)
Home Setting			
With at least one parent	86%	83%	85%
Relative or foster parent	14	17	15
Source of Referral			
Detroit Public Schools	37	47	40
Out-County Schools	26	10	21
Juvenile Court	26	25	26
Other*	11	18	13
Referral Problem**			
School Behavior	46	48	47
Incorrigibility	18	37	24
Property Offenses	14	7	12
Truancy	11	15	12
Sex Problem	8	10	8
Fire Setting	8	0	6
Other	27	17	24

* Includes 26 patients; 21 of these were referred by private hospitals or child guidance clinics.

** Several children are represented in more than one "Referral Problem" category.

F. THE PROGRAM

A number of positive aspects can be listed about the program of the Training School. It compares favorably with activities involving this patient group in other institutions in the country. The program is patient-centered and reflects the professional leadership of the Medical Superintendent. The staff is conscientious and diligent in its daily care of patients and the planning of improvements.

The program is multi-professional in approach. The aim is the treatment, education, and training of the mildly retarded school-aged child within a residential setting. The county ordinance requires that the chief executive be a psychiatrist, implying that the program is conceived as basically medically-psychiatrically oriented.

A conscientious effort is made to tailor plans to the needs of each child. Lack of resources, however, often limit the staff. Although there is collaboration between the various treatment disciplines, certain areas lack an over-all guiding basic philosophy. Because of staff shortages, medical-psychiatric leadership in daily planning of treatment for patients is not always discernible. There is no single professional person or discipline charged with the responsibility for constant evaluation of the effect of the program on the individual patient, his status, and his readiness for release. Therapeutic plans could be better established and goals more easily achieved were one treatment discipline given a clear-cut daily responsibility for each patient.

Several therapeutic components can be identified. In addition to the effects of daily life in the cottages, educational, vocational, psychological, social, and medical interventions play major roles.

1. Children live in cottages; daily life is under the supervision of the cottage personnel. Through their continued contact these employees probably make the greatest impact on the development of the patients.

A lack of involvement of registered nurses in this program was noted.

Parents are encouraged to maintain an interest in their children. The benefits of such relationship could be further developed, however, through liberalization of rules regarding visits home and to the school.

General recreational programs are provided to break the monotony of institutional living.

2. Education plays a most significant role in the total program. Of all treatment endeavors it reaches the greatest number of residents. Up to the age of 15 the children attend school full-time; between 15 and 16, half-time. The school offers a spectrum of classes including the pre-academic level, generally serving children under 11; the academic; and manual activities classes for the older patients. Within classes there are further specializations, and a remedial program in reading.

   Education is centralized in the institution's school. At times, the program appears insufficiently integrated with the rest of the therapeutic endeavors.

3. In the vocational training program, an effort is made to prepare the patients for the work demands of life upon release. They are expected to meet ordinary competition and, hopefully, achieve economic independence. Between the ages of 15 and 16 youngsters spend half of their learning time in the vocational program; those over 16 are assigned on a full-time basis. Nearly half of the population participate in the vocational program. A variety of resources are utilized--the kitchen, the bakery, the laundry, the power plant, the maintenance shops, the barber shop, gardens, the farm, etc. Vocational assignments are training- rather than service-oriented, and represent an extension of the manual activities classes of the institutional school.

4. The psychology staff provides a psychodiagnostic examination of all newly admitted patients, and a re-evaluation at regular intervals. Thereafter many are seen on special referral from members of the other departments. Eighty-three outpatients were also examined in 1959-60. The relatively small number of residents who receive individual and group psychotherapy are ordinarily treated by members of the psychology staff. Psychiatric supervision, or even consultation, is available only to a very limited extent.

5. The social service department, because of staff shortages, must restrict its primary activities to work with pre-admission and convalescent patients. Though many patients come from families with substantial problems, continued case work is rarely available, either to the average resident patient, or to his family.

Of the ten social workers, only one has a master's degree in social work from an accredited school.

6. Medical services are provided largely by the University of Michigan. A faculty member from the Department of Pediatrics visits the Training School once a week and is on call at other times. He supervises a full-time pediatric resident assigned to the Training School on a rotating basis. Most patients are physically reasonably healthy, and their somatic needs are probably adequately covered through the available resources. Those who become ill are transferred to the infirmary, and those more seriously sick are referred to outside resources, such as the University's Medical Center at Ann Arbor, or the Wayne County General Hospital.

Because of vacancies, the only currently available full-time physician is the Medical Superintendent. This shortage is particularly felt in the adequate planning and administration of psychiatric treatment, or even consultations. Many patients manifest significant emotional pathology. Total care would require the greater availability of psychiatrists on a full-time, part-time, or consultant basis.

7. In recent years two special programs were also initiated:

   a. Intensive treatment for a group of 25 emotionally disturbed, retarded boys. A building formerly used as employees' quarters was converted into living, treatment, and educational facilities. In addition to an intensified total milieu approach, the patients receive individual and group psychotherapy. The institution's school, through the assignment of two teachers, provides a specialized educational program.

   b. A day school program has been offered since 1957. Retarded children between the ages of 4 and 8 from nearby communities participate. They come from school districts which, at present, have no special classes for them. The major share of the expense, the teachers' salaries, is borne by the districts where the students reside. The parents underwrite the noon meals, and the Training School provides the space. As many as 45 young pupils participate in three classes.

8. Traditionally, much emphasis has been placed on research, particularly of an educational and psychological nature. Under the leadership of a full-time director of research and training a number of investigations were conducted which contributed significantly to the professional literature. Several doctoral dissertations were also written. The Training School owes much of its reputation to this program.

   Recently--partly because of shortage in personnel--considerable retrenchment has taken place. Only few investigations are underway and the research unit is but a section of another department. The aim is to reduce overlapping functions, but this step of reorganization also lowers the status of research. De-emphasis of this very important activity might become a consequence.

9. Training of personnel has been another historical activity of the Training School. As a result, several former employees have achieved prominence. Changes in composition of the patient population and in treatment goals re-emphasize the need for intensification of this program. Unfortunately, limitations in resources might have again contributed to restrictions. Intensification and broadening of training will ease transitions in general programming, decrease recruitment problems, and increase the effectiveness of the personnel. In any training program, the needs of the cottage life or nursing group must be given a high priority.

CHAPTER V

THE WAYNE COUNTY COMMUNITY*

A. DEMOGRAPHY

Wayne is the most populous of Michigan's 83 counties; 34% of the people live there. During the last decade, growth of the state, as a whole, was greater than of the county (see Table VII). Wayne County has a higher concentration of foreign-born residents (14.4%) than the state as a whole (9.5%). Within the county there has been a shift in population distribution. The number residing in Detroit declined, while the "out-county" grew. In 1950 Detroit had 76% of the county's residents; by 1959 it had only 66%. Losses occurred mostly in the dense areas with relatively low family income, and gains were made in the less populated areas with higher standards of living.

The county is one of the wealthiest in Michigan. It is known as a center of industry. It also has a tradition of planning for and meeting the needs of its citizens in such areas as education, health, welfare, and juvenile justice. Quality and quantity of services have historically compared favorably with other regions of the state and the U. S.

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*Data contained in this chapter were obtained from a number of sources. A diligent attempt was made to reconcile discrepancies in the information available.

TABLE VII

State and County Population Changes

	Population in Millions		Percent Change
	1950	1960	
Michigan	6.37	7.79[1]	+22.3%
Wayne County	2.44	2.67[1]	+ 9.8%
Wayne County Residents, Age 6 - 19	.47	.63[2]	+34.7%

[1] Figures based on preliminary reports of the 1960 U. S. Census

[2] Based on school census figures 1958-59

B. THE YOUTH

While the total population of the county increased by only 10% during the last decade, the number of youths between the ages of six and twenty grew by 35% (Table VII). Today there are over 630,000 in this age group; nearly one-half million of them in schools. The growth in pupil population is most striking in the out-county area, which has 34% of the county's population, but 42.5% of the public school students.

C. NEEDS OF THE YOUTH AND THE RESOURCES

The 630,000 young people of Wayne County require many public services. At least some of these are not fully adequate. Several of the unmet needs were brought forcibly to the attention of the survey team.

1. The Juvenile Offenders

The juvenile court processes approximately 5,000 children per year. An effort is made to apply up-to-date concepts in dealing with these youthful offenders, but basic facilities, personnel, and programs were described as insufficient. In spite of a sizable population growth, no additional facilities have been added to the state Boys' Vocational School for 60 years. The recidivism rate of its graduates was quoted as being 73.6%. The demand for space is apparently so great that many youthful offenders must be released before they are considered sufficiently rehabilitated.

Some community representatives considered intensification of individualized rehabilitation of the delinquents, both at the local and state level, a high priority need. A plea was made particularly for better follow-up services. It was suggested that at least part of Wayne County Training School be converted to a minimum security facility for boys and be used for the follow-up treatment of returnees from the Boys' Vocational School, or probationers from the juvenile courts in need of follow-up or short-term residential treatment. It was felt that the

need for this type of service would continue even if the construction of additional state facilities for delinquents were expedited.

Little mention was made of deficiencies in services for delinquent girls.

2. Emotionally Disturbed or Mentally Ill Children

Several community representatives indicated that the emotionally disturbed and the mentally ill children form another group inadequately served in Wayne County. Recently the State Legislature authorized school districts to establish special education for these children; however, few classes are in operation.

In Detroit and its environs there are over 300 inpatient beds for the emotionally disturbed or mentally ill youth. The facilities include, among others, the children's units at Ypsilanti and Northville State Hospitals; the Hawthorne Center; the children's unit at Lafayette Clinic; and at the Neuropsychiatric Institute at Ann Arbor. Some of these beds are not reserved exclusively for Wayne County children and serve the state as a whole. There is a waiting list of about 150 patients from Wayne County, attesting to these unmet needs.

The lack of emergency psychiatric care and of short-term residential treatment for disturbed children was also emphasized. The suggestion was made that all or part of Wayne County Training School be used to house such programs.

3. Physically Handicapped Children

The problems of children afflicted with such conditions as blindness, deafness, epilepsy, cerebral palsy, or other physical handicaps were not stressed. The needs of some of these groups are probably satisfied reasonably well. However, shortages likely exist in services for children with neuromuscular disorders. Problems of

these handicapped children might not have been emphasized by representatives of the agencies because the physical structures of the Training School do not lend themselves to the care of the infirm.

4. The Retarded

The Training School has no waiting list. It is able to meet the demands in the restricted area of the mildly retarded adolescents. Shortages for other retarded individuals were strongly expressed.

Accurate data are not available concerning the number, the age, and the IQ distribution of the retarded individuals in Wayne County. It is generally estimated that approximately 3% of a population is at least suspected of mental retardation, or so diagnosed during life. Assuming that the diagnosed group at any one time represents only 1%, the number would amount to 27,000 persons in the county. The case finding rate would be highest in the school-aged group. One can assume there are at least 18,900 retarded in the 6 through 19 age range (3% of 630,000).

The Detroit schools have approximately 5,700 pupils in special classes and about 400 more are awaiting placement in the program. The out-county schools serve more than 1,100 children in special classes, and there are over 1,000 on the books of the Wayne County Training School. From the county approximately 4,000 patients of all ages are in the state homes and training schools. However, in spite of recent expansion of state facilities there is still a waiting list of over 460 from Wayne County to Lapeer State Home and Training School alone.

The shortages in many programs for the retarded--residential as well as outpatient--came into focus during the survey. Even quantitatively the needs of few subgroups are met.

The various community representatives stressed different priorities:

a. The critical need for institutional beds for the more severely retarded of all ages became most obvious. Much of the waiting list to state institutions is composed of patients in this category. Community programs are equally short for this subgroup.

b. Both residential and community facilities for the moderately retarded or trainable children are also in short supply. Public school classes for them have developed at a slower pace than those for the educable. Many are on institutional waiting lists. In the community, sheltered workshops, recreational, and similar programs are nonexistent or, at best, rare. Patients of all ages in this category were considered inadequately served, with greatest emphasis on the pre- and post-school groups.

   For the youngest the only significant programs described were those conducted by parents' groups which operate a few private nursery schools serving some 100 children. The growth of the parent movement might indicate further expansion. The parents, however, felt that public agencies should assist them more substantially.

c. In the mildly retarded, shortages were most strongly accented for the post-school-aged group. Parents of Wayne County Training School students joined other community representatives in this expression of need. The Training School does not admit children beyond the age of 15, and most are discharged by the time they reach 19. Public school education is mandatory from 6 to 16, and permissive from 3 to 21. However, the number of mildly retarded in the public schools rapidly declines after the mandatory school age.

Several community representatives, and the parents, thought the Training School should extend its age limits for admission and retention. Often voiced as areas of deficit were: pre-vocational preparation; assistance in job finding and job adjustment; and the provision of sheltered workshops at the Training School and in the community.

d. The needs of the multi-handicapped retarded were not strongly emphasized during the survey, probably because representatives included them in the moderately or severely retarded subgroups. The Training School facilities are also generally known to be unsuitable for the care of the physically handicapped.

D. RESOURCES IN INSTITUTIONS OF HIGHER LEARNING

In the development of professional training and research programs, institutions of higher learning play a vital role. The Training School is in an advantageous position because the Detroit area is an educational center. There are two major universities within reasonable distance of the Training School, the University of Michigan and Wayne State University. They provide undergraduate and graduate training in practically all fields related to child care and the care of the retarded, including medicine, public health, social work, education, psychology, and others. Both have ongoing and active research interests. Their resources could become available for cooperative programs at the Training School.

Several significant facilities of the State Department of Mental Health are also conveniently located. Among them are the Lafayette Clinic, the Hawthorne Center, the Plymouth State Home and Training School, and two state hospitals for the mentally ill. Representatives of the Department expressed willingness to develop collaborative training and research programs.

CHAPTER VI

GENERAL CONSIDERATIONS

Observations and comments on the Training School and the county were presented in the previous chapters. Before recommendations are made, certain general considerations must be presented.

A. IDENTIFICATION OF COMMUNITY NEEDS AND THE SOLUTIONS

Not all pertinent facts could come to light during the brief study period. Shortages in community services can be best identified through carefully planned epidemiological studies, which assure that all needs have an equal probability of being uncovered. The Committee had to rely on the information furnished by representatives of significant community agencies and other citizens. To any community agency, a problem assumes great proportions when it comes to attention in a dramatic way, and when resources are inadequate for a proper solution. Needs so identified do not necessarily coincide with those which result from careful and systematic studies.

Identification of community needs should be followed by delineation of the best available remedial measures. Present knowledge, however, is insufficient to make categorical recommendations for many of the behavioral and social ills of our day. Only a series of controlled experiments could shed the necessary light. Time is short for this purpose, and some recommendations and actions cannot await maximum knowledge. Decisions must often be based on judgment, rooted in current practice. It is desirable, therefore, to present the basic considerations which guided the Committee members in arriving at decisions.

B. TRADITION AND THE PROBLEMS OF CHANGE

Thirty-five years ago Wayne County made a historic decision to assume direct responsibility for a group of its fellow citizens. It declined to wait until the state provided resources, and voted funds for construction and for the year-to-year operation of

the Training School. The people of Wayne County considered it advantageous to have a program of their own, the quality and quantity of which they could control. The mildly retarded adolescents in need of residential care were clearly identified as the beneficiaries of their efforts.

Tradition is an important sociological force, but it should not be considered a permanent mandate. Conditions change and there is need for re-examination of past decisions so that they might be brought into step with new circumstances. A radical departure, however, should be the result of compelling arguments and judicious deliberations, rather of temporary issues or expediencies.

Major changes pose unique operational problems, particularly in programs in which the results greatly depend upon interpersonal relationships. Therapeutic work in the mental health field requires considerable training, which is a slow process. With a high degree of competence comes substantial specialization. A staff oriented to serve certain types of patients cannot be expected overnight to care for a different group. Therefore, sudden shifts in the over-all program may require the replacement of one treatment cadre with another. Gradual changes, on the other hand, are possible without disruption in the stability of the program, particularly when the necessary gradual retraining is provided.

The limitations of the Training School plant must be taken into account in plans for any changes. Most of the buildings lend themselves to the care and treatment of ambulatory patients requiring minimal security measures.

C. MENTAL RETARDATION IS A COMPLEX PHENOMENON

Mental retardation is commonly defined as ". . . subaverage general intellectual functioning which originates during the developmental period and is associated with impairment in adaptive behavior."*

*Heber, R.: Modifications in the Manual on Terminology and Classification in Mental Retardation, Am. J. Ment. Defic. 65:499, 1961.

The usual symptoms are significant defect in intelligence, delayed maturation, handicap in learning, and deficiencies in social adjustment. Little disagreement exists concerning the diagnosis of the retarded at the trainable or lower levels.

In the mildly retarded categorization becomes a far more difficult problem. The question of diagnosis arises only when specific behavioral, emotional, or learning problems call attention to the individual's conflict with standards of our society. Case finding is highest during adolescence, particularly among the socially, culturally, or economically deprived groups; the minorities; and the delinquents. Disruptions in the home environment commonly trigger the diagnostic process. The clinician is always confronted with a complex picture and the need for corrective action. The availability of resources often influences his decisions.

It is particularly difficult to separate the mildest degrees of retardation from normalcy, either on the basis of an IQ score or through any other criteria of examination. The physician, therefore, must ultimately rely on his clinical judgment when integrating all the presenting symptoms. Admission to a residential institution is rarely considered simply because the measured level of intelligence of the individual is below an arbitrary cut-off point. It is no longer necessary or justified to admit a retarded child to an institution purely for educational reasons. The development of special classes in the public schools eliminated this need to a great extent. Admission is usually the result of behavioral, emotional, or social complications. These points are re-emphasized because of concern expressed that the Training School might be admitting patients who, by ordinary standards, would not qualify for admission to some institutions for the retarded.

Adolescents with mild intellectual impairment represent but one sub-group of all mentally retarded people. In program expansion, others should always be considered. They include individuals outside the adolescent age range and those who are more severely afflicted, or who suffer from multiple handicaps.

D. PRINCIPLES OF TREATMENT

Certain generally accepted principles of psychiatric treatment should be considered in program planning.

1. Treatment should be started as early as possible. It is desirable to initiate remedial measures at an early date, particularly in children, rather than to wait for the development of a more severe symptomatology. In the mildly retarded, failure in school soon grows into disinterest, truancy, and delinquency. Remedial education, combined with psychiatric treatment, offers a way to interrupt this chain of events. Early treatment can often be provided on an outpatient basis. Therefore, a residential treatment facility must concern itself with outpatient activities.

2. Treatment should be provided with as little dislocation in mode of living or in the geographical placement of the patient as possible. No child should be removed from his home and his community except for compelling reasons. When special education is the child's only crucial need, classes should be provided in community schools to avoid the necessity of residential placement.

3. No child should remain in an institution any longer than is necessary. As soon as possible he should be returned to his home or to a foster setting. Follow-up treatment is often needed and can be offered on an outpatient basis. An aftercare program becomes a significant responsibility of a residential operation.

4. Age of a child or of an adolescent is a most important concern. Children and youth are developing human beings. Growth of the retarded occurs at a rate slower than that of normal children. It is desirable, therefore, to think of programs geared to the needs of youth and supportive of their development. Children, even if suffering from a variety of chronic impairments, fit better into a program oriented to age, than into a service designed for adults with similar conditions. Programs established specifically for adolescents have a number

of advantages.

5. Children are part of the family constellation. Healthy growth of any child depends upon his close contact with parents or parent substitutes. Clinical symptoms are often an expression of the conflicts of the significant adults around the child. Psychiatric treatment is most effective when these adults are also involved in the process. A hospital for youth must include the family in its therapeutic procedures.

6. Institutionalization in itself carries dangers of producing superimposed handicaps. Even the best residential setting is an artificial environment for a child who is later expected to take his place in society. Life in an institution should resemble that in the community. All programs available to adolescents on the outside should be provided in the hospital setting and geared to the special needs of the patient population. The educational, recreational, spiritual, vocational, and other experiences of the hospitalized child should at least be on a par with those of his normal age-mates. Ties with family and community should be maintained and fostered. Visits back and forth must be encouraged.

7. Institutionalized youth must be prepared for independent adulthood. He must be trained to earn a livelihood. For the mentally retarded vocational preparation is of equal, if not greater, importance than academic learning. Good work habits and job attitudes, and the ability to get along with co-workers, are as important as specific skills. Institutional job assignments should be strictly treatment-oriented and patients should not be involved in industrial programs primarily for production's sake.

The vocations for which the patient is trained must be selected with the labor market in mind. Job opportunities are limited for the retarded; he should be prepared for those in which he has a reasonable chance to succeed,

and in which the community needs his services. The farm program of the Training School should be reviewed in light of changing agricultural technology.

8. Primary responsibility for the planning and administration of treatment must be assigned to one profession. In a broad program several disciplines are involved. Each patient is treated through many modalities. Individualized plans should, however, be made for him. He must be re-evaluated as to the effects of the treatment and restudied for his general progress. Unless a single professional group, through one of its members, assumes responsibility for his total program, efforts of a team likely become fragmented and diluted.

In a large facility there is a need for a basic therapeutic philosophy that permeates the orientation of the total treatment staff. The contributions of other professions must be recognized and fostered, but leadership should remain centralized.

In the Training School it is particularly important that educational endeavors become closely integrated with the primary goal--total treatment of the child.

9. Continuity of treatment must be emphasized. Residential admission should always be considered as a temporary measure initiated for a specific purpose and be terminated as soon as possible. Treatment can often be started before admission and, if needed, should be continued upon release. Shift in treatment personnel is undesirable just because a patient moves from an outpatient phase to a residential one, or back again. The hospital must make its resources available to patients prior to admission and after release.

10. An institution is one segment of a total community program. In the past they were often considered operational entities removed from and independent of community planning. Today a residential setting should be considered but one modality of treatment in the total

health, welfare, and educational plan of the community. Avenues in and out of it should be open and flexible. Institutions like the Training School must remain continuously sensitive to community needs and adjust their programs to changes.

Volunteer services are an important way of maintaining community ties. They also contribute to the over-all treatment program of an institution.

E. STATE OR LOCAL RESPONSIBILITY

Most major mental health programs have traditionally been operated by public agencies. State and local governments have played important roles. State management has the advantage of its over-all size and the extent of its fiscal resources. Local administration helps assure that facilities will be close to the people served. The lower levels of government can more directly control services and remain more responsive to changing local needs.

The present trend in the United States favors local administration. Community mental health services are being established in increasing numbers, often subsidized by higher governmental bodies.

F. THE NEED AND THE POSSIBILITIES FOR CHANGE

Significant changes have already taken place in the program of the Wayne County Training School. A number of children are admitted who do not fit the traditional stereotype of the mentally retarded. Their intellectual functioning is higher but their superimposed emotional disturbances are probably greater than was the case ten or twenty years ago. Many of these children come to the Training School because they need residential care, but do not fall into any clear category which coincides with the intake policy of other available community resources. These changes occurred spontaneously and followed the direction of local demand. Further shifts in programming are unquestionably forthcoming. Planning for these changes has advantages over leaving the matter to chance.

The trend in community needs is likely to follow the pattern which produced the present changes. The direction most clearly lies toward increased involvement of the Training School in the problems of the emotionally disturbed child or adolescent and the pre-delinquents who cannot remain at home or in a foster setting.

A school-aged population will probably remain the concern of the Training School. The question could therefore be raised whether this agency should be primarily a "school" which is treatment-oriented, and provides certain therapeutic services, or whether it should be a "hospital" which concentrates on intensive treatment and provides the needed teaching and training facilities. Clues to the answer come from the fact that educational needs alone rarely, if ever, should result in placement of a child in an institution. The primary pathology of the majority of the patients is of an emotional nature. The need is for intensive treatment to allow the child to return to his home and to the public schools.

"Schools," whether residential or not, should have educational leadership. In the United States governing bodies of school systems are not usually interested or experienced in operating 24-hour-care facilities.

G. THE USE OF OTHER LOCAL RESOURCES IN PROGRAM DEVELOPMENT

Lack of knowledge limits our ability to serve and research becomes an obligation of any large service agency. Continued training of personnel helps to assure the use of up-to-date skills. Training is particularly important in an institution that is undergoing significant changes. The resources of universities can contribute much to the program. Research and teaching affiliations between service agencies and universities become of prime importance. Historically they have always resulted in mutual benefits. A large institution provides resources for training assignments and field experimentations. The service agency gains from the consistent stimulation of faculty members. The degree of integration of a service

institution and the community can be gauged by the affiliations of the agency with the local schools of higher learning. The Training School is ideally located to take advantage of the resources of the metropolitan area and the nearby universities.

Training programs so developed must involve all or most of the institutional personnel, from the top administrator to the newest employee. Some aspects of teaching can best succeed on a structured, formal basis; others, from informal consultations and the exchange of ideas. The latter process is particularly beneficial to the top personnel of the institution.

CHAPTER VII

RECOMMENDATIONS

The survey was conducted to review the needs of the mentally retarded in Wayne County and to recommend modifications, if indicated, in the program of the Training School. Changes have already taken place. There is a trend toward admitting patients who are less retarded but manifest a greater degree of superimposed emotional disturbances. An intensified treatment program was started for a limited number of these patients, and a part-time service was initiated for a new group of children in the form of a day school. Further shifts can be expected. These should be anticipated and the necessary plans developed for them.

Several choices are open for the future. Some changes will have an impact for many years; others are of a more immediate nature. Legislative and administrative adjustments might be required for implementation of certain changes.

The ultimate decisions belong to the Administrative Board, the Board of Supervisors, and the citizens of Wayne County. It is hoped, however, that these recommendations will assist in the necessary deliberations.

A. MAJOR ALTERNATIVES

Five major avenues for the future, their advantages and disadvantages, were discussed in detail by the Committee:

1. Continue the operation of the Training School along present lines without modifications.

2. Plan for a complete change in clientele served and in the program itself.

3. Transfer the Training School to the Michigan State Department of Mental Health.

4. Transfer the Training School to an educational administrative body.

5. Retain the operation and administration of the Training School and plan for gradual changes.

B. THE RECOMMENDED ALTERNATIVE

After careful consideration, the Committee recommends:

> That Wayne County retain the operation and administration of the Training School, with gradual changes in its program.

The Committee favored this solution for a number of reasons. For many years the Training School has provided a very important service. It has developed a major tradition, and has been a source of pride to the community. It pioneered concepts in treatment, patient activities, and techniques of special education. Many of these have been adopted by other institutions.

The community has invested much in capital, in operational costs, and in staff development. The personnel of the Training School represent an important asset which should not be lost. These people have worked together for years. They are competent and could only be replaced through a long process of training and experience. Though they could not be utilized at once for the treatment of an entirely new type of patient group, their services for the retarded are still needed.

The public is identified with the program. Its support provided the resources which made it possible for the school to assume leadership in the field of mental retardation. For a considerable time the Training School was well ahead of most facilities in the country. It can again become a model establishment in program development, community services, research, and professional training. This opportunity for renewed national leadership is the primary basis for the above recommendation.

Operation under county auspices assures the maintenance of local control, enabling the citizens of Wayne County to determine the type, the quality, and the quantity of services which they desire and can support. Programs can be provided at a level unrelated to that available to the rest of the state. The institution can remain

sensitive to changes in community needs and adjust to them relatively quickly. Shifts in focus, expansion in one area, and retrenchment in another can be accomplished without major disruptions.

The Training School can again pioneer broad new concepts of services for the retarded or other youth. It can develop examples of: integration between intra- and extramural programs; community consultations; and collaborative enterprises with other resources such as universities, public schools, and private medical practitioners. It can become a center of research and training.

Briefly, it can become a model of the ways in which a traditional institution can become integrated with the broad health, welfare, and educational programs of a community. These contributions could become of national importance in our days of changing mental health concepts.

Such a program requires strong public backing and substantial financial resources. In the long run, however, the benefits will outweigh the cost.

C. THE OTHER ALTERNATIVES

The Committee considered the other major alternatives less desirable.

1. Continuation of the present program would not stop the changes that are occurring. It would only leave the outcome to chance.

2. A complete change in the types of patients admitted would leave the mentally retarded, including those in residence, without some of the present services.

   Two patient groups were suggested for consideration in such program planning:

   a. The delinquent in need of minimal-security residential facilities, either under local court

jurisdiction, or upon release from the Boys' Vocational School, and

b. The emotionally disturbed and the mildly psychotic youth in need of emergency or short-term inpatient services.

It was thought that the facilities of the Training School could be used for either group, or a combination of the two.

It is doubtful that the present personnel could adequately serve in these new areas without prolonged retraining. Years of their experience in the field of retardation would be lost. Services are needed for the delinquents and the emotionally disturbed; however, programs should be developed anew, or present facilities expanded.

3. The transfer of the Training School to the Michigan State Department of Mental Health has certain advantages. The state program needs beds for the mentally retarded, and in this way it could acquire an additional capacity of about 700 without much construction lag. The present Training School facilities could be used for the mildly retarded, freeing beds elsewhere for the more severely deficient and for the infirm. In some respects this gain is more apparent than real. A sizable number of beds would only become available if appropriate patients of the Training School were rapidly discharged.

Assimilation of the Training School into the state program would minimize possible duplications and standardize care for the mildly retarded throughout the state. The proximity of the Training School to the new Plymouth State Home and Training School would lend itself to unified administration and economical management. The combined facility would be located in Wayne County, close to metropolitan Detroit, assuring the citizens of the area of the availability of a nearby comprehensive

state institution for the retarded. Transfer of the personnel from county to state service could be achieved without geographic dislocation of the people involved.

The state would acquire, for a nominal sum, the physical facilities, and the operational costs would be borne by the state rather than the county.

On the other hand, the county would lose its capital investment, its control of a very significant program, and surrender policy-making prerogatives concerning level of services. The present operation would become but a part of a much larger undertaking. It would be geared to state-wide needs and serve Wayne County only insofar as general resources permit. Sensitivity to county needs would likely gradually disappear. Agreements could be worked out assuring Wayne County of certain considerations, which--though made in good faith--might become subject to repeated review by the state legislature.

4. The transfer of the Training School to an educational administrative body would establish an entirely new undertaking, posing some of the problems of any complete change. The affirmative arguments are that the public schools refer a large number of the new patients--61% in 1959-60--and most of those in residence are of school age. Their educational program would remain more continuous were the residential institution administered by a school system. Intramural and extramural curriculums could be integrated and mobility between day and residential school might become simpler. The institution would acquire a new educational philosophy. Emphasis on therapy would probably diminish, though treatment could be provided on a consultative basis.

Several negative arguments must be considered. Most educators and school boards, particularly at the local level, are neither experienced in nor enthusiastic about the administration of residential schools. Their central obligation is the public day school. Some state depart-

ments of education maintain specialized residential schools, but if the Training School were transferred to such a state agency, Wayne County would lose local control.

If operated by a school system within the county, a question would arise concerning which system should become responsible for the institution. The Board of Education of the City of Detroit is the chief referral source. However, the school is not located within its geographic area. The Wayne County Board of Education could assume the responsibility and operate it on a contractual basis with each local school district. Such arrangement would require a number of legislative, administrative, and financial changes.

Perhaps the strongest argument against this solution is that most patients do not enter the institution for educational reasons alone. Though failure in the classroom is a common symptom, behavioral problems, emotional disturbances, and the disruption of the home are more important precipitating factors for admission. Education must be continued while the child is in residence but it should remain corollary to the primary aim of treatment.

D. THE CHANGES IN PROGRAM

As stated earlier, the Committee recommends that the county continue the operation of the Training School, because it could again become a pioneer undertaking of general benefit to the county, with great significance to the state and the nation. Several suggestions for changes are made; some can be instituted early while others will require time.

The Training School should retain its primary interest in services to the mildly retarded adolescent. An increasing proportion of future patients are expected to be intellectually more capable, but manifesting a greater degree of superimposed behavioral, emotional, and sociological handicaps. Within a decade a review might show that significant impairment

in intelligence is present in only a segment of the patients. Gradually the Training School might become a comprehensive psychiatric hospital for adolescents.

This broadening of the program will require flexibility in admission criteria. The administration and the staff should be given latitude in the upper and lower age limits--for admission and retention. The determining factors for admission should be the needs of the patient and the institution's ability to serve him; and for retention, the continued necessity for residential treatment.

To an increasing extent therapeutic activities should be expanded to include partial hospitalization, extramural, and follow-up services. The need for inpatient beds might then decrease, freeing physical facilities for the development of the newer modalities in treatment.

Major emphasis on community orientation should increase the Training School's active part in the development of resources throughout Wayne County and assist in the integration of the county-wide program.

Research and professional training should become a core sphere of interest.

It might be found that some programs can more effectively operate in the nearby communities rather than on the grounds of the Training School. The administration should be given freedom in selecting the most suitable locale.

Some of these changes will require alterations in laws, and flexibility in budgeting, administration, organization, and program planning, but will achieve the goal of integrated comprehensive services for the mildly retarded in Wayne County, centered in a model institution.

E. DIRECT SERVICES TO PATIENTS

Inpatient treatment is one major modality of therapy. It is indicated when intensive intervention is needed, and when other resources are not available. It should be used as an alternative, rather than a preference, to the part-time approach. Broad programs in extramural services, in part-time hospitalization, and in aftercare are therefore recommended. Individual treatment plans should be flexible enough to permit the patient's movement from one modality to another with minimal disturbance in the continuity of treatment.

1. Extramural Services

A number of important diagnostic and treatment procedures can be conducted on an outpatient basis. This modality of services should be the first choice in most cases.

The diagnostic workup of a mildly retarded adolescent rarely requires more than office visits. A clinic geared to this type of work can see many patients and develop a specialized service of importance to the community. It should emphasize the psychiatric diagnosis and utilize the corollary professions. The clinic work does not have to expand significantly to the field of somatic medicine as this should be provided by family physicians.

The outpatient services can become a very fruitful source of consultation to physicians, the public schools, the probation department, and other health and welfare agencies. Practical advice, based on a good diagnostic process, often enables patients to remain in the community.

Frequently treatment can also be administered on an outpatient basis. Individual or group psychotherapy, casework and family counseling, and continued work with the social environment do not necessitate inpatient admission.

2. Partial Hospitalization

Some patients require intensive treatment efforts which cannot be concentrated into the brief visits of the ordinary outpatient hours. Day hospitalization is then a choice. The patient can still maintain his family ties and receive most of the therapies available to inpatients. In addition to the techniques described under extramural services, the program should include corrective and special education, vocational preparation and guidance, and the opportunities of a sheltered workshop.

The night hospital is another type of partial hospitalization. It is particularly suitable for the older adolescent patients who are unable to adjust to the community on a 24-hour basis, but are ready to try their skills in outside jobs. Under this plan some resident patients might also attend classes in the public schools.

3. Total Hospitalization

Full hospitalization should be retained for those patients who require intensive total therapy. One of the most important aspects of this treatment is the hospital milieu. Highly-trained, therapeutically-oriented ward-level personnel, under adequate professional guidance, are the necessary tools. Full-time hospitalization affords more economical utilization of patient and staff time by appropriate grouping of treatment endeavors. Greater accent can be placed on individual and group psychotherapy, vocational preparation, special education, and the development of good living and work habits.

Total hospitalization has a major impact on the patient and his family. Continued and intensive collaborative work with parents and other family members is necessary throughout the period. Social casework should prepare the family for the return of the patient.

The length of inpatient stay should be minimized. Every patient should be re-evaluated regularly to ascertain

his readiness for release. The present population should be reviewed with this principle in mind. The patient's time should be spent in programmed activities--treatment, training, education, recreation, or rest.

4. Aftercare

Patients should be returned to the community as soon as possible. Many will require further treatment, support, and supervision, which can be continued in the extramural services or through partial hospitalization. An adequate follow-up program, with emphasis on social work, is the key to success. Many families will require intensive casework during the period of adjustment to the newly returned patient.

At times there might not be any family to accept the adolescent. Placements in foster settings become a necessity. Home finding and supervision of the patient and the foster parents are obligations of the aftercare services.

Most boys and girls, upon release from the institution, will be ready to work. Job finding and support during their vocational adjustment are additional services which should also be available through the aftercare program.

F. THE TREATMENT PERSONNEL AND ORGANIZATION OF TREATMENT SERVICES

1. The Treatment Personnel

Comprehensive direct services require a variety of professional and semi-professional personnel. Improvement in quantity and quality will reflect itself in increased efficiency. The formal training of members of several professional departments is beyond reproach. Some departments are also adequately staffed. Four basic areas, however, require urgent strengthening:

a. There is insufficient professional time available for the planning and administration of psychiatric treatment, or even consultation to other departments. The only full-time psychiatrist is the Medical Superintendent. The present program requires several additional psychiatrists on a full-time or part-time basis. The expanded program, as outlined, demands even more.

b. There is a critical shortage of social workers, particularly those fully qualified by graduate training. There is, therefore, an equal need to improve both the quantitative and qualitative aspects of the social service department.

c. Increased recognition of the emotional components in the patients' pathology will place an additional burden on ward personnel. They must be prepared for their role in the treatment process through an intensified training program.

Psychiatrically-trained registered nurses become a core group in the daily treatment of patients. Their contributions were emphasized in the report of the Central Inspection Board of the APA, and are again underscored.

d. The development of a strong volunteer service, guided by a full-time coordinator, would assist in the treatment activities and improve liaison with the community. This suggestion was also among the first recommendations made by the Central Inspection Board.

2. The Organization of the Treatment Services

The treatment services must be organized in a fashion to give structural support to a unified patient-centered approach. It is necessary that all personnel involved in direct treatment be ultimately supervised by a single

individual whose primary concern is the therapeutic program. The Superintendent himself could not adequately fulfill this function because of his numerous other obligations.

It is recommended that a qualified psychiatrist be appointed as Assistant Superintendent, Treatment Services, responsible to the Medical Superintendent, and be placed in charge of the direct services to patients. His leadership would assure that the basic psychiatric orientation will remain in constant focus.

The individual professional departments should report to this assistant medical administrator.

The growth of extramural, part hospitalization, and aftercare services will gradually require that psychiatrists be placed in charge of each program. As inpatient treatment is intensified it might become necessary to divide the institution into subunits, each headed by a psychiatrist.

This type of organization will result in improved integration among the various treatment disciplines and professional departments. There is a most specific need to strive for a closer collaboration between the institutional school and the other therapeutic endeavors.

Each patient should have available the benefits of all professional approaches. Treatment teams should be organized by wards or by specialized programs. The team should be guided by a psychiatrist and be composed of representatives of other disciplines involved in the care of the patient; i. e., nursing; social work; psychology, education; occupational, recreational, and vocational services; and other therapists. Communication between team members should be facilitated through frequent exchanges of ideas; and through conferences involving plans for the individual patients and the over-all program of the unit.

G. COMMUNITY SERVICES

The broadening of direct services to patients, particularly the establishment of outpatient clinics and an aftercare program, will intensify the working relationship between the institution and the public. The Training School has an obligation to the community which should not be limited to services provided to individuals. It should assume leadership in the broad planning and coordination of county programs in the field of retardation, with emphasis on the mildly retarded adolescents.

A unit of community services should be established, staffed by personnel trained in the public health aspects of psychiatry and in community consultations and organization. Its activities would include public education concerning the problems of the retarded, and the development and maintenance of liaison with significant individuals as well as public and private agencies. The key organizations and people include the public schools, the courts, the welfare and probation departments, the medical profession, the vocational rehabilitation groups, volunteer organizations, churches, service clubs, and a number of other benevolent groups. Close liaison with the Commission on Children and Youth should be maintained.

Collaborative work should be concerned with immediate and specific problems and the establishment of long-term, county-wide plans.

The intermittent examination of needs of the retarded of Wayne County should be a responsibility of the community services unit. It should undertake epidemiological investigations of its own, stimulate other agencies to do so, or evolve collaborative plans for studies. The School of Public Health of the University of Michigan could be of substantial assistance. Available resources could be matched with identified needs and community interest stimulated to alleviate the shortages.

Wayne County--through the activities of this unit--would have constantly available information on the needs of the retarded and the resources for them, and therefore be ready for public action.

H. RESEARCH

Research is an obligation of any large service agency. The Training School, until recently, has always maintained a high level of research activity.

It is recommended that a full-time research director be appointed. His position might be, at least temporarily, combined with that of the chief of professional education. He should be responsible for stimulating and coordinating the research efforts of the staff, for conducting studies, and for developing research liaison with nearby universities. Representatives of major research organizations expressed their desire to use the facilities of the Training School, and to become involved in joint endeavors. The members of the professional staff should be encouraged to participate in research projects.

A high-level research program will produce important information, new knowledge, better understanding of the patients, and an improved evaluation of the effects of treatment. It will enhance interest in professional training and sharpen the clinical acuity of the staff.

The research team should focus upon the evaluation of the treatment program, particularly when a new service is established. Some therapeutic projects will be of a demonstration nature; their acceptance by other institutions, or their incorporation into the Training School's general program, will depend upon their effectiveness as measured by the evaluation process.

The quality of any research program is dependent upon the knowledge and skill of the personnel. Many clinically oriented professionals lack the necessary degree of research sophistication and it becomes imperative that consultants be utilized. Qualified individuals in practically all related disciplines are available from a number of nearby research centers.

I. TRAINING

There is a serious shortage of qualified professional personnel in the field of mental retardation, which is reflected in local, state, and nation-wide recruitment problems. Through the

strengthening of its professional training program, Wayne County Training School could make an important contribution. The institution has a tradition and is presently involved in the training of some professionals. It is advantageously located close to two major universities and several other institutions with active programs. Affiliations could be developed with individual training agencies or with a combination of them. Representatives of several significant centers have expressed their desire and willingness to assist and to collaborate. Advantage should be taken of these opportunities.

Psychiatric residents from the Lafayette Clinic, the Neuropsychiatric Institute of the University of Michigan, the Hawthorne Center, and some of the state hospitals might be involved in rotating assignments, particularly if a stimulating, intensive training program is developed. Public health personnel could gain experience in retardation. Psychologists, teachers, and social workers could also use the facility for internships and field assignments.

The Detroit area is rich in professional opportunities. The staff should be encouraged to attend meetings, seminars, and workshops. They should be urged to seek appointments in institutions of higher learning and be given an opportunity to carry out their acquired obligations. Outside teaching consultants should also be brought to the Training School. In this fashion an interchange of ideas between the staff of the institution and the university faculty would be stimulated.

The development of a coordinated program requires the employment of a chief of professional training, responsible directly to the Medical Superintendent. As mentioned before, he could also be in charge of the research program.

Training acquires a particular significance in an institution which is undergoing changes. The staff will be prepared for new responsibilities. Its efficiency will improve and the quality of the service program will be enhanced. Recruitment problems will diminish and close working relationships with schools of higher learning will develop.

J. ADMINISTRATIVE AND ORGANIZATIONAL CHANGES

In previous sections suggestions were made concerning direct services to patients, treatment personnel, the community orientation of the institution, research, and training. Major changes will be involved which require planning and gradual implementation. The over-all administrative and organizational structures of the Training School should be adapted to the demands of the work which lies ahead. In this context, the following broad suggestions are made:

1. The Establishment of a Professional Advisory Committee

The Training School is an independent agency of the county government. In management and fiscal matters it is represented by the Administrative Board, which also reflects the wishes of the public concerning over-all services. By ordinance the Board is composed of prominent citizens, including representatives of the educational and legal professions. There is also a need for top-level representation of medicine, including psychiatry, social work, psychology, and other allied treatment professions. Members could be added to the Administrative Board, which, however, would result in significant enlargement and operational problems.

It is therefore recommended that a separate advisory committee be established, of seven to nine members, and composed of representatives of the above-mentioned professions, including education. Leaders in their respective fields should be appointed, for overlapping terms, by the County Board of Supervisors, or by the Administrative Board. In view of the program re-orientation, training, and research, it is desirable that institutions of higher learning be adequately represented on this committee, assuring liaison with the teaching and research fields.

The Professional Advisory Committee should be consultant to the Medical Superintendent and to the Administrative Board. Work of the Committee and the

Board should be integrated by cross representation between the two bodies.

2. Strengthening of the Administrative Structure

The Medical Superintendent will be faced with increasingly complex responsibilities. Great demands will be placed on him by changes in program, their planning, implementation, and evaluation. Liaison with the public, the Board of Supervisors, the Administrative Board, the Professional Advisory Committee, and institutions of higher learning will require much of his time. He will still retain ultimate responsibility for the day-to-day operations of the Training School.

The Medical Superintendent should be provided with top-level associates able to assume considerable administrative functions. At least three highly-qualified assistant administrators, responsible directly to him, should be appointed. A physician, preferably a psychiatrist, should be charged with the development, coordination, and implementation of all treatment and community services. Another physician, preferably a psychiatrist, should head the research and training program. The third assistant administrator should become responsible for all non-treatment functions, such as business and personnel management. These associates should participate with him in the over-all planning of programs; therefore, their own supervisory responsibilities should also be reduced through a limited span of control.

3. Flexibility in Job Classifications and Filling of Positions

As shifts in the program occur, the need will arise for greater priority in certain classes of personnel. The administration of the hospital will be aware of the changes in requirements. With the approval of the Administrative Board, the Medical Superintendent should be able to modify requirements in positions as vacancies occur. For example, it may become obvious that a reduction in the security force is possible, but there is a need

for a larger number of physicians, nurses, or cottage life personnel. These changes could be accomplished gradually, in anticipation of needs, without violation of the principles of the merit system.

Economy is a pertinent requirement in a public program; however, it is desirable to assure that services will be provided at least at the budgeted level. It is recommended that the restrictions on refilling of available positions be eliminated. Their rejustification in each instance consumes time and hampers recruitment. The Medical Superintendent should be authorized to fill positions expeditiously, in accordance with civil service regulations.

4. Re-evaluation of Certain Current Operations

As changes in program occur, there will be a constant need to re-evaluate certain traditional activities. The farm and dairy operation is selected as an example. It has been part of institutional life for many years, but recently authorities have questioned its therapeutic value and fiscal merits. Only a careful study of its contributions toward training of patients for employment on farms will evaluate therapeutic benefits. The results must then be balanced against cost figures.

5. The Recommendations of the Central Inspection Board of the American Psychiatric Association in 1957 and 1960

It is strongly recommended that the improvements suggested in the above reports be implemented.

6. Change in the Name of the Institution

The recommended changes would substantially alter the basic orientation of the institution. To an increasing extent it would become a psychiatric treatment center for adolescent patients with emphasis on mental retardation. Consideration should be given to changing the name of the institution to reflect the directions of the new program.

K. FISCAL RESOURCES

The operating costs of the Training School are at present largely borne by the general funds of Wayne County and the reimbursements from the State Department of Mental Health. Findings suggest that other fiscal resources should be explored. The major possibilities are:

1. An increase in per diem reimbursement from the state, to bring this sum to the level of the cost of care of patients in state institutions.

2. Subsidies from the state educational funds based on the contributions which the state would make to the districts if the pupils were in local community schools.

3. Contributions might be obtained from the local school districts equalling the amount they would spend were the students not at the Training School.

4. The improvement in the training and research programs would likely attract the resources of granting agencies such as the Federal Government and private foundations.

Any success would decrease the burden on the county general fund. The primary consideration, however, must always be the needed quantity and quality of care.

APPENDIX A

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Deputy Superintendent
Delaware State Hospitals
Farnhurst, Delaware

M. D. - University of Louisville - 1929

Diplomate, American Board of Psychiatry and Neurology (Psychiatry)
Certified, Mental Hospital Administrator

Private Practice, Kentucky, 1929-42
U. S. Army Medical Corps, 1942-46
Superintendent, Dixon (Illinois) State Hospital, 1949-54
Acting Superintendent, Manteno (Illinois) State Hospital, December 1953 to May 1954
Director, Architectural Study Project, American Psychiatric Association, 1954-56
Chief Inspector, Central Inspection Board, American Psychiatric Association, 1956-60

Fellow:	American Psychiatric Association
	Southern Psychiatric Association
Member:	Washington Psychiatric Society
	American Medical Association
	District of Columbia Medical Society

LEONARD J. DUHL, M. D.
Psychiatrist
Professional Services Branch
National Institute of Mental Health
Bethesda, Maryland

M. D. - Albany Medical College - 1948

Diplomate, American Board of Psychiatry and Neurology (Psychiatry)

Associate in Psychiatry, George Washington University, Washington, D. C.

Fellow, Menninger Foundation School of Psychiatry (Menninger Clinic), 1949-54
Candidate, Washington Psychoanalytic Institute, September 1956-present
Senior Assistant Surgeon, Public Health Service, Contra Costa County, California, 1951-53
Member, Research Advisory Committee, Office of Health, Education, and Welfare, 1956-57

Fellow:	American Psychiatric Association American Association for the Advancement of Science American Public Health Association
Member:	American Association on Mental Deficiency (Board of Editors, American Journal of Mental Deficiency, 1957-present. Councilor, 1959-63) Group for the Advancement of Psychiatry American Orthopsychiatric Association Washington Psychiatric Society Society for Applied Anthropology
Affiliate:	Royal Society of Medicine, London

BENEDICT NAGLER, M. D.
Superintendent
Lynchburg Training School and Hospital
Colony, Virginia

M. D. - University of Hamburg - 1923

Diplomate, American Board of Psychiatry and Neurology (Psychiatry and Neurology)

Assistant Professor of Psychiatry and Neurology, Medical College of Virginia, 1946-present
Associate Professor of Clinical Neurology, Georgetown University Washington, D. C., 1953-57. Professorial Lecturer since 1957.
Lecturer, Department of Neurology and Psychiatry, University of Virginia, 1957-present

Consultant: In Psychiatry to Committee on Reorganization of State Government in Virginia, 1949
National Institute of Neurological Diseases and Blindness, 1953-present. (1953-57, Neurological Study Section and National Advisory Neurological Diseases and Blindness Council. 1958-present, Neurological Field Investigation Study Section.)
Veterans Administration (Neurological Research) 1957-present

Associate Examiner, American Board of Psychiatry and Neurology, 1953-present

Private Practice, 1931-43
U. S. Army Medical Corps, 1943-46
Chief of Neuropsychiatric Service, VA Hospital, Richmond, Virginia, 1946-53
Chief, Neurology Division, Psychiatry and Neurology Service, VA, Washington, D. C., 1953-57

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DR. NAGLER (continued)

Fellow:	American Psychiatric Association (Member, Committee on Mental Deficiency)
	American Academy of Neurology (Member, Board of Trustees, Chairman of Committee on Problems of Mental Retardation)
	Southern Psychiatric Association
Member:	American Association on Mental Deficiency (Chairman-Elect, Mid-Eastern Region)
	American Epilepsy Society (Past Councilor)
	Association for Research in Nervous and Mental Diseases
	American Electroencephalographic Society
	Southern Electroencephalographic Society (Past President)
	Lynchburg Academy of Medicine
	Virginia State Medical Society
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	Virginia Neuropsychiatric Society

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American Psychiatric Association
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M. D. - Tufts School of Medicine - 1942

Diplomate, American Board of Psychiatry and Neurology (Psychiatry)

Professorial Staff, University of California (Los Angeles) 1948-58
(Department of Psychiatry, School of Medicine; Department of Psychology, Graduate School. Psychiatric Consultant, Student Health Service.)

Consultant: Office of the Surgeon General, United States Army
Veterans Administration, Psychiatry and Neurology Service
Walter Reed Army Medical Center, Psychiatry Service
American Medical Association, Council on Mental Health
New Sibley Memorial Hospital, Washington, D. C.

On Board of Directors and/or Professional Advisory Committee of:

American Child Guidance Foundation
American Society of Mental Hospital Business Administrators
National Association for Mental Health
National Health Council
White House Conference on Aging, 1961, Planning Committee on Health and Medical Care

Editor-in-Chief, Mental Hospitals, 1958-present
Editorial Board, Excerpta Medica, 1953-56

U. S. Army Medical Corps, 1943-46
Private practice, 1948-58

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DR. ROSS (continued)

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	American Association for Advancement of Science
	American Geriatrics Society
	Gerontologic Society, Inc.
	Southern Psychiatric Association
	North Pacific Society of Neurology and Psychiatry (Honorary)
Member:	Group for the Advancement of Psychiatry
	Southern California Psychiatric Society
	Washington Psychiatric Society
	American Medical Association
	California Medical Association
	Los Angeles County Medical Association
	Medical Society of the District of Columbia
	Southern Medical Association
	American Academy of Political and Social Science
	American Association of University Professors
	American Public Health Association
	World Federation of Mental Health (Associate)
	Association of American Medical Colleges
	Society of Medical Consultants to the Armed Forces
	Scientific Associate, Academy of Psychoanalysis

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M. D. - University of Budapest - 1935

Diplomate, American Board of Psychiatry and Neurology (Psychiatry and Child Psychiatry)
Certified, Mental Hospital Administrator

Clinical Professor, Department of Psychiatry, University of California (Los Angeles) 1954-present

Member:
- Mental Health Project Grants Review Committee, National Institute of Mental Health, 1960
- National Advisory Mental Health Council, 1960-
- Commission of the Association for Research in Nervous and Mental Diseases
- International Preparatory Commission of the International Association for Child Psychiatry and Allied Professions for the 5th International Congress for Child Psychiatry, 1960-

Private Practice, 1935-39
Utah State Hospital, 1941-43
U. S. Army Medical Corps, 1943-46
Clinical Director, Peoria (Illinois) State Hospital, 1946-47
Clinical Director, Pacific State Hospital, 1947-49

Fellow:
- American Psychiatric Association (Past Councilor and present Chairman of the Committee on Mental Deficiency)
- American Association on Mental Deficiency (Past President, Past Chairman of Southern California Region)

Member:
- Group for the Advancement of Psychiatry
- Southern California Psychiatric Society (Past President)
- American Medical Association
- California Medical Association
- Los Angeles County Medical Association (Past President, Pomona Branch)

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Pacific State Hospital
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B. A. - New Mexico Western College - 1947
M. A. - Colorado State College of Education - 1950
Graduate Study - University of Southern California

U. S. Navy, 1942-45, 1951-52

Lecturer in Special Education, University of Southern California, 1960-present

Director of Special Education, Santa Maria, California, 1957-59

Member: American Association on Mental Deficiency
California Teachers Association
International Council for Exceptional Children
Affiliate Teachers of Los Angeles
National Science Teachers Association

SHELDON J. BROWN
Supervising Psychiatric Social Worker
Pacific State Hospital
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B. A. - University of Denver - 1939
Graduate Year in Public Administration - 1939-40
M. S. W. - University of Southern California, School of Social Work - 1946-48

Student Field Work Supervisor, University of Southern California, School of Social Work, 1949-53
Coordinator of Social Group Work and Psychiatric Social Workers Training Program for University of Southern California, School of Social Work, 1953-present
Instructor, Fullerton Junior College, Fullerton, California, 1952-present
Preceptor in Social Work for the Western Interstate Commission on Higher Education, currently
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Member: American Association on Mental Deficiency
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Pacific State Hospital
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B. A. - Psychology, University of California at Berkeley - 1943
M. P. H. - Hospital Administration, University of California at Berkeley - 1951

Preceptor, Western Interstate Commission on Higher Education
Consultant in Mental Retardation to the Western Interstate Commission on Higher Education
Preceptor, Administrative Interns, Pacific State Hospital

U. S. Marine Corps, 1943-46
Recruitment and Placement Officer, VA Hospital, Palo Alto, California, 1946-48. Personnel Training Officer, 1948-50
Administrative Resident, Agnews (California) State Hospital, 1951-52
Administrative Assistant and Personnel Officer, Modesto (California) State Hospital, 1952-53

Member: American Association on Mental Deficiency
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B. A. - University of Southern California - 1948
M. S. W. - University of Southern California - 1951

Consultant, University of Southern California School of Social Work
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Preceptor, Administrative Interns, Pacific State Hospital
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U. S. Army Medical Service Corps, 1952-54
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APPENDIX B

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The Committee gratefully acknowledges the assistance of Dr. Pasquale Buoniconto and his staff for furnishing much of the background data, for the innumerable contacts they made for the Committee with citizens of Wayne County, and for their generous arrangements for the site visit and the interviews.

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Supervisors and of the Board's
Wayne County Training School
Committee