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AN HISTORICAL ANALYSIS OF PUBLIC POLICY FOR THE  
CARE AND TREATMENT OF PEOPLE WHO ARE  
MENTALLY RETARDED IN MICHIGAN

by

Kenneth O. Slater

A Dissertation  
Submitted to the  
Faculty of The Graduate College  
in partial fulfillment of the  
requirements for the  
Degree of Doctor of Public Administration  
Center for Public Administration Programs

Western Michigan University  
Kalamazoo, Michigan  
August 1986

AN HISTORICAL ANALYSIS OF PUBLIC POLICY FOR THE  
CARE AND TREATMENT OF PEOPLE WHO ARE  
MENTALLY RETARDED IN MICHIGAN

Kenneth O. Slater, D.P.A.

Western Michigan University, 1986

This dissertation traces the historical development of Michigan's public policy associated with the residential care and treatment of mentally retarded people. Michigan laws and programs from 1830 through 1983 were studied after being compared to a national history. The central question was: What factors, over time, influenced public policy related to residential care and treatment of the mentally retarded?

Initially, care was the responsibility of families and friends of the mentally retarded. This responsibility shifted from townships to counties, then to the state during the nineteenth century. Until the late 1800s many mentally retarded people were housed on county poor farms and in asylums for the insane. In 1895 the first state institution for the mentally retarded opened in Lapeer, Michigan.

The Lapeer State Home and Training School for the Feebleminded developed as a school designed to ameliorate mental retardation. By the 1930s Michigan's facilities had become large institutions to protect

society from the retarded who were perceived as deviant. Institutions continued to grow in number and size between 1900 and 1960.

In the 1960s major changes began to take place in Michigan's public mental health system. The change process was studied using a framework developed by the Council of State Governments. The change factors studied included governmental initiatives, interest group actions, social consensus, resource availability and judicial opinion.

Change in Michigan public policy regarding the mentally retarded was influenced by combinations of change forces considered. Between 1960 and 1983, governmental initiatives and interest group action appear to have had the most direct, long-term impact on changing services. However, determination of degrees of influence was not within the scope of this study and quantitative rankings were not developed.

Public policy in Michigan has come full circle. In 1830 the mentally retarded were a familial or local responsibility. By the 1900s many were being moved into state institutions. Today the emphasis is again on family responsibility. Changes in the laws, population definitions and programs have been greatly influenced by both interest group actions and governmental initiative.



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## DEDICATION

This work is dedicated to the memory of Leonard F. Montgomery (1927-1986) who taught me how to persevere even in the most adverse conditions.



## ACKNOWLEDGEMENTS

Many people have provided immeasurable assistance in this phase of my lifelong education. I first wish to acknowledge the valuable assistance given by the members of my dissertation committee, Dr. William Ritchie and Dr. Donald Sellin. The patient counsel of Dr. Ralph Chandler, chairperson, encouraged me to do more than simply "muddle through."

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To my family who for the last five years have tolerated my academic pursuits, I owe the greatest debt. I thank Donna for loving me. I thank Erin for being my favorite oldest daughter and Lindsey for being my favorite youngest daughter.

Finally, my interest in mental retardation and history was created by my parents and grandparents. My education is a manifestation of my parents' intelligence and wisdom. Therefore my achievements are really theirs.

Kenneth O. Slater

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## CHAPTER I

### INTRODUCTION

This dissertation traces the historical development of public policy related to the residential care and treatment of people who are mentally retarded in the State of Michigan. It is an attempt to select, analyze and write about the past, to better understand the present and prepare for the future.

Society's approach to people who are mentally retarded has changed as society changed. Sarason and Doris (1979) point out that characterizations of people, and how a society acts in relation to them, reflects time, place and societal values. They state, "Mental retardation says as much about us as it does about them" (p. 15).

Perceptions, definitions and reactions to people who are mentally retarded have often reflected society at a particular time. More specifically, public policy regarding housing and care for the mentally retarded may reflect that society's view toward other larger disadvantaged or devalued groups. Wolfensberger (1972) addresses devaluation from the perspective of deviancy. He writes, "A person can be said to be deviant if he is perceived as

being significantly different from others in some aspect that is considered of relative importance, and if this difference is negatively valued" (p. 13). The mentally retarded frequently have been perceived as deviant in relation to other groups in society.

One might view mental retardation as a lens through which to observe society. Unfortunately, most researchers do not use this lens because of ahistorical, or even antihistorical, approaches to public policy. For the creators and users of public policy the problem is not one of ignoring history, but rather a failure to comprehend its value.

In relation to the field of mental retardation, an understanding of history can provide a foundation for the development of future public policy. Understanding the factors that have caused policy to change over time can provide impetus for additional changes based on the needs of the people who are most affected by public decisions and policy--the mentally retarded.

Although numerous national and global histories of mental retardation have been written (Davies, 1959; Kanner, 1964; Krishef, 1983; Rosen, Clark & Kivitz, 1976; Scheerenberger, 1983), no current history of mental retardation exists for the state of Michigan.

Without such a history it is difficult for policy planners to link events of the past with concepts and

ideas for the future. Their history is only as deep as their immediate memories. Historical analysis of public policy for the residential care and treatment of people who are mentally retarded in Michigan can reach back to remind the reader of how state policy reached its present form and what factors influenced its development.

Parents, professionals, politicians, legislatures and courts have all played a significant role in the definition and treatment of persons classified as mentally retarded. The multi-faceted approach to mental retardation which exists in the United States is a product of the nation's political democracy and pluralistic society. A historical perspective on the public policy produced by this society can assist in understanding and harmonizing these pluralistic concepts.

#### The Research Question

In order to develop a historical perspective and analyze Michigan's public policy for the residential care and treatment of the mentally retarded, a research question and several subsidiary questions were devised. The question at the center of this analytical history is: What factors, over time, have influenced public policy in the area of residential care and treatment of people who are labeled mentally retarded in the state of Michigan?

In addition to identifying the course of public policy, and the elements that have influenced that course throughout Michigan's history, several related questions were raised:

1. Have governmental or non-governmental organizations been the impetus behind policy changes regarding the retarded in Michigan?
2. Have public policy changes occurred because of legislative, administrative or judicial actions?
3. What has been the impact of litigation on public policy regarding the retarded in Michigan?
4. Are there identifiable patterns within the development of Michigan's policy?
5. How has state budgetary policy influenced residential care for the mentally retarded?
6. Have changes in Michigan's public policy paralleled shifts in national public policy and periods of reform?
7. How have ideological concepts such as human rights and human potential influenced Michigan's policies?

These questions will be considered in the course of developing the overall history of residential care in Michigan and will be integrated into the text of each of the chapters.



## Organization

This dissertation is divided into two primary parts. The first (Chapter II), focuses on a general history of residential care and treatment of mentally retarded people. The purpose of this chapter is to present a broad perspective on how society has cared for the retarded through the centuries. The early sections of the chapter primarily concentrate on developments in western Europe and their influence upon American programs and policy in the eighteenth and nineteenth centuries. The latter portions outline the history of services through the first eighty years of the twentieth century. Chapter II is designed to provide a back-drop so that the imprint of national and international history upon policy development in Michigan can be seen.

The second part of this dissertation is divided into two chapters, III and IV. Both focus on the laws, population definitions and programs for the mentally retarded in Michigan.

Chapter III begins with Michigan as a territory in the early 1800s and ends in 1960. It documents public policy development through this period by reviewing enacted laws and programs established to provide care and treatment for the mentally retarded. Views held by societal members at various points across this time

period are used to describe and define this population.

Chapter IV assesses the years between 1960 and 1983. Using a policy framework suggested by the Council of State Governments, the evolution of laws, population definitions and programs is evaluated. The factors or change forces which have influenced public policy over time will be studied in order to identify primary influences on policy development in Michigan.

Chapter V will summarize the history of public policy development as it relates to the residential care and treatment of the mentally retarded. Emphasis will be placed on the factors which have shaped Michigan's policies and the implications these have for public administrators working in the field of mental retardation. Suggestions for additional research will also be included in Chapter V.

### Methodology

This study is primarily documentary research. By nature, such research involves collecting evidence derived from documents and records, and from that evidence formulating conclusions. As Davidson and Lytle (1982) point out, history is the act of selecting, analyzing and writing about the past. It is something that is constructed and not simply created by retrieving data from an archives (p. xvii). Glaser and Strauss

(1967), in describing the generation of grounded theory (in contrast to theory generated by logical deduction from a priori assumptions), point out a purpose of sociological theory. They state, "it is a strategy for handling data in research, providing modes of conceptualization for describing and explaining" (p. 3). By using documentary evidence, this research attempts to construct, explain and conceptualize some of the factors related to residential public policy in Michigan.

Although the central purpose is to develop a historical chronology of residential care of the mentally retarded in Michigan, a framework to identify influential factors has been utilized in Chapter IV. The framework is a modification of one suggested by the Council of State Governments.

#### Sources of Evidence

The primary sources of evidence available to assess the factors that have influenced mental retardation policy in the state of Michigan are the records and reports of the Michigan Department of Mental Health and predecessor agencies. Materials included reports, studies, administrative records, correspondence and transcripts of hearings involving state agencies.

These, and all other documents used, were appraised both externally and internally. As Hillway (1964)

suggests, external examination must be used to determine the genuineness or authenticity of the document, while internal examination is concerned with the meaning and accuracy of the document's contents. Hillway adds: "The evidence of a given document can be considered relevant to the problem only if it is demonstrably and unquestionably related and suitable--that is, if it has real bearing on the problem" (p. 163).

The resources of the State of Michigan Archives and the Library of Michigan were used in securing primary sources, whenever possible.

### Terminology

Much of the terminology used in original sources may seem pejorative to the modern reader. Words such as idiot, feeble-minded, moron and lunatic may appear more like degrading labels than technical descriptors. Many legislative classifications did not reflect professional typologies nor classes of services. For example, the term insanity was used for many years to describe a large number of disabilities, including mental retardation. In addition, terms were often used in an inconsistent manner not having the specificity that they have today. The word trainable, for example, has been used to designate people who could be trained to do a task, as well as, a specific classification in the State education system.

It is important to note that although such terms were rarely complimentary, they were not intended to be pejorative in their original usage.

More significantly, the original terms reflect the contemporary thinking of policy makers on the nature of pressing social problems. For example, moral imbecility was described by Kerlin (1889) as "a loss of control over the lower propensities, or that in which the moral sentiments rather than the intellectual powers are confused, weakened, or perverted" (p. 33). For forty years this was an accepted definition for a form of mental retardation. In short, expressions used may be a vital portion of the historical research of public policy for the mentally retarded and therefore were retained in their original form.

#### Summary

This study traces the historical development of public policy related to the residential care and treatment of mentally retarded people in Michigan. It is an attempt to provide a written chronology of this history and to identify factors that have influenced public policy in this area.

Mental retardation has often been viewed in an ahistorical manner, emphasizing etiology, diagnosis, systems and bureaucracies. The social historical

influence of mental retardation has often been forgotten. People are prone to see current public policy issues separate and apart from those of previous generations. The separation of past and present should not be the case. Much current policy has particles of past policy mixed in with the new, and the following chapters demonstrate how this has occurred.

History is linked to the future. By increasing knowledge of factors influencing the public policy of the past, it is anticipated that prospects for future policy development will be enhanced and seen as part of a continuum rather than independent policy decisions. Ideally, this view could guide the continuing development of public policy and have positive impact upon those most affected by it--people who are mentally retarded.

## CHAPTER II

### A BRIEF HISTORY

In order to understand and analyze the development of public policy related to the mentally retarded one must first have an appreciation of the history of retarded people. As Sarason and Doris (1979) point out, mental retardation is not comprehensible apart from the moral and ethical values that emerge over the course of social history. The purpose of this chapter will be to develop a concise history of the care and treatment of the retarded which will provide a context for the analysis of public policy in subsequent chapters.

Any given society has had members who were more capable and less capable than the average. Yet the impact of being a member of the less capable group has varied from society to society. Characterizations of other people and how a society reacts to them reflects time, place and the values of that society. When viewed historically these characterizations can be useful in gaining a broader perspective on the process by which a society develops policy for groups of people. Bogdan and Taylor (1976) note:

If one wishes to understand the term holy water, one should not study the properties of the water, but

rather the assumptions and beliefs of the people who use it. That is, holy water derives its meaning from those who attribute a special essence to it.

Similarly, the meaning of the term mental retardation depends on those who use it to describe the cognitive states of other people. As some have argued, mental retardation is a social construct or a concept which exists in the minds of the "judged" (Blatt, 1970; Braginsky & Braginsky, 1971; Dexter, 1964; Hurley, 1969; Mercer, 1976). A mentally retarded person is one who has been labeled as such according to rather arbitrarily created and applied criteria.

Retardate, and other such clinical labels, suggests generalizations about the nature of men and women to whom that term has been applied (Goffman, 1963). We assume that the mentally retarded possess common characteristics that allow them to be unambiguously distinguished from all others. It is as though humanity can be divided into two groups, the "normal" and the "retarded." (p. 47)

As a social, as well as scientific concept, mental retardation has undergone dramatic change as the following description shows. Twenty years ago Best (1965) would say that the retarded "constitute the lowest stratum, intellectually, in human society. The lowest are so low that they can be said hardly to live as we generally know the term; they are hardly more than organisms--they vegetate rather than live" (p. 3). Two decades later change is evident in the literature. Works such as Quality of Life in the Severely and Profoundly Retarded (Meyers, 1978), Diminished People: Problems and Care of the Mentally Retarded (Bernstein, 1970) and Mental Retardation: From Categories to People (Cegelka, 1982) urge a much more humane and human view of the



retarded. Yet their history begins long before the last half of the twentieth century.

### Antiquity

Records indicate that severe forms of mental retardation were probably recognized by people in antiquity. Harms (1976) reports that skull fragments found in Denmark indicate that a trephination (removal of a small portion of bone from the skull) had been performed on an infant with hydrocephalus perhaps 10,000 years ago. Indications are that such treatment was done to expel demons which caused mental disorders or epilepsy (Scheerenberger, 1983, p. 4).

Records of infanticide, where the grossly deformed and female children were destroyed, are common throughout ancient history (Solecki, 1971; Sumnar, 1906). In Our Oriental Heritage, Will Durant (1935) describes this practice.

Most nature peoples permitted the killing of the newborn child if it was deformed, or diseased, or a bastard, or if its mother had died in giving it birth. ...The practice of infanticide was particularly prevalent among nomads, who found children a problem on their long marches. ...Infanticide was practiced without cruelty and without remorse; [sic] for in the first moments after delivery, apparently, the mother felt no instinctive love for the child. (p. 50)

Although infanticide continued in many societies for centuries, Abt (1965) notes the exception of Babylon.

Any abnormality in an infant was seen as a predictor of its future welfare and the welfare of the family. Stone tablets dating to 1700 B.C. recorded sixty-two omens used to prophesy from birth defects (Kretchmer, 1964). Infanticide was not viewed as the way to escape omens and children were probably not intentionally destroyed.

Similarly, Harms (1976) proposed that disabled children in Egypt may have been protected by the followers of Osiris, the god that gave Egypt its civilization. The Egyptians were also some of the earliest peoples to provide care for the sick through the use of their healing temples (Bullough and Bullough, 1969).

Between 500 and 400 B.C. the Hebrews in Palestine established moral and legal codes which showed sensitivity to the handicapped and poor persons of that time. Examples of these codes found in the Pentateuch include:

When your brother-Israelite is reduced to poverty and cannot support himself in the community, you shall assist him as you would an alien or a stranger, and he shall live with you (Lev. 25:35).

You shall not treat the deaf with contempt, nor put an obstruction in the way of the blind (Lev. 19:14).

You shall not ill-treat any widow or fatherless child (Ex. 22:22).

How these codes affected the mentally retarded is not known, but it appears that abuse of disadvantaged

people was prohibited by the Hebrews.

### Greece and Rome

The ancient Spartans and Romans on the other hand, made it a practice to eliminate severely defective individuals by abandoning them and exposing them to the elements. Davies (1959) points out that the ancient Greeks treated the severely retarded in a harsh eugenic manner. Defective children were cast into rivers or left to perish on mountainsides. He says, "The laws of Lycurgus countenanced the deliberate abandonment of 'idiots,' a practice which was probably followed by a certain extent throughout Greece, and according to Cicero, amongst the Romans also" (p. 8).

Plato (1928), in the Republic, wrote that the weak and retarded were of little use to society. He stated:

The principle has already been laid down that the best of either sex should be united with the best as often, and the inferior with the inferior, as seldom as possible; and that they should rear the offspring of the one sort of union, but not of the other, if the flock is to be maintained in first rate condition. ...The proper officers will take the offspring of the good parents to the pen or fold, and then they will deposit them with certain nurses who will dwell in a separate quarter; but the offspring of the inferior, or of the better when they chance to be deformed, will be put away. (pp. 412-413)

Aristotle (1943) had similar ideas about handicapped children. In Politics he wrote, "As to the exposure and rearing of children, let there be a law that no deformed

child shall live" (p. 315). He also noted the cause of "deformed" children. He writes, "Men who are too old, like men who are too young, produce children who are defective in body and mind; the children of a very old man are weakly" (p. 316).

Durant (1939) notes that the Spartans were most severe. Every child faced a father's right to infanticide and a state council of inspectors. A child that appeared to be defective was thrown from a cliff off Mt. Tayetus to die on the jagged rocks below (p. 81). Deutsch (1946) found in Alcibiades II, a document dated about the time of Plato, a classification of different kinds of unsoundness of mind. It reads:

Those who are afflicted by it in the highest degree are called mad. Those in whom it is less pronounced are called wrong-headed, crotchety, or -- as persons fond of smooth words would say -- enthusiastic or excitable. Others are eccentric, others are known as innocents, incapables, dummies. ...All of these kinds of unsoundness of mind differ from one another as diseases of the body do. (p. 9)

Words such as innocents, incapables and dummies are descriptors of the retarded that have carried down through the centuries. Davies (1959) notes that the Greeks provided the root words for the term idiot, a term of classification used in early twentieth century America. He says, "The word idiot is presumably derived from 'iditas,' a private person, or 'idios,' peculiar, that is a person set apart or alone" (p. 8). The idea

was that mentally retarded people lived in a world by themselves and were outside the norms of society in terms of public citizenship.

A second term, imbecile, underwent a semantic change that oriented its usage to the mentally retarded. Originally, imbecillis meant weak and was used by the Romans to describe any form of debility. Over time it was reserved to indicate weakness of the mind, less severe than that of an idiot (Kanner, 1964, p.5).

Scheerenberger (1983) notes that in Rome the mentally retarded were subjected to a wide range of living situations and treatment. Of course one must remember that almost 1300 years are encompassed in Roman history, from 800 B.C. until 476 A.D. During the early Republic many elements of Greek culture were found in Rome. Durant (1944) writes, "Birth itself was an adventure in Rome. If the child was deformed or female, the father was permitted by custom to expose it to death" (p. 56). The power of the father was absolute; he alone having rights before the law. He had the power of life, death and sale of children into slavery.

Very little is known about the care and treatment of the retarded during this period. Durant (1944) does note that Livia, the third wife of Augustus, devoted herself to charity by helping large families and providing dowries for poor brides. She also, reportedly,

maintained many orphans at her own expense (p. 229-230).

Scheerenberger (1983) notes that during this period it was also common for unwanted children to be mutilated and raised to be beggars. One account records a debate addressing the question whether those who mutilated these children had done wrong by the state. It was concluded that since these children were in essence slaves, no wrong was done the State (p. 54).

From this same era Kanner (1964) quotes from a letter written to Lucilius from Seneca, the sometimes mentor to Nero. In epistle number 50 he wrote:

You know that Herpaste, my wife's fool, was left on my hands as a hereditary charge, for I have a natural aversion to these monsters; and if I have a mind to laugh at a fool, I need not seek him far, I can laugh at myself. This fool has suddenly lost her sight. I am telling you a strange but true story. She is not aware she is blind and constantly urges her keeper to take her out because she says my house is dark. (p. 5-6)

It appears that the purpose of the retarded was to provide amusements to the wealthy of the day. It should be noted however that Seneca was more benevolent than many of his fellow countrymen and continued to care for Herpaste instead of putting her to death as was common.

During the last half of the first century contributions made by Claudius Galen (A.D. 138-201) had significant impact on the understanding of intelligence. Galen was a philosopher and scientist who conducted neuroanatomical research on pigs, because the use of

humans was prohibited. He concluded that the brain (as Plato thought) was the seat of the soul and not the heart (as Aristotle thought).

Galen thought that not only the quantity of brain substance but also its quality was important. Zilboorg's (1941) translation notes, "The keenness of the mind depends upon the fineness of the brain substance. Slow thinking is due to heaviness. ...Its firmness and stability produce the faculty of memory" (p. 91). Galen determined that imbecility resulted from the rarefaction and diminution in quantity of the animal spirits and from the coldness and humidity of the brain (p. 92). Galen's ideas influenced concepts about the retarded and other "mental defectives" for centuries.

Some mentally impaired infants may have been placed in one of the various charitable facilities established as early as A.D. 97. During the rule of Nerva, an attempt was made to curtail infanticide by founding colonies for poor families and assisting the indigent. Abt (1965) notes that under Trajan approximately 5000 children were cared for by the state. Later, Hadrian (A.D. 117-138) compelled parents to raise their children instead of exposing them.

Friedlander's (1928) annals record that by the second century A.D. Roman life had denigrated to the point that there was a "market of natural freaks at which

men without shanks, with short arms, three eyes, pointed heads, might be bought" (p. 221). The accuracy of such accounts is difficult to verify, but the same author also notes that, as had been the practice for centuries, the courts of the wealthy kept and exhibited "real cretins and other freaks" for the entertainment of guests.

By the fourth century A.D. Christianity was beginning to exert its influence. Emperors such as Constantine, Valentinian and Theodosius issued edicts against infanticide and the selling of children into slavery. Philosophies espousing that the weak, disabled and ill were closer to God and that helping the afflicted was a sign of strength and not weakness became prevalent.

As Scheerenberger (1983) notes the height of Roman achievement was its law. Provisions for the protection of all but the most seriously disabled and diseased existed. Justinian is the ruler credited with compiling the comprehensive legal code that summarized Roman law. This code indicated that the mentally disabled should not suffer the same penalties as others. He established institutions for the poor and provided a system of guardianship for some mentally disabled persons (p. 20).

To summarize this period, it is probably safe to conclude that the majority of mildly retarded individuals went unnoticed by society. They found themselves in much the same impoverished illiterate and enslaved conditions



as the masses of society. Those that were part of the wealthier class undoubtedly received some medical treatment and were accepted as members of a family. The more severely impaired did not survive beyond infancy, except in cases where they were used as beggars or household fools. The care and treatment of the mentally retarded in these centuries so greatly influenced by the Greeks and the Romans were dependent upon parentage, class and existing societal culture.

### The Middle Ages

During the 1,000 years known as the Middle Ages many charitable works by individuals, church and state are recorded. Most action toward helping the less fortunate was at the urging of the church. Unfortunately little research was done in this area because of religious doctrine prohibiting it. The exception to this policy was research carried out by the Arabian physicians, most notably Abu Ali al-Husayn ibn Sina, better known as Avicenna. Avicenna wrote extensively and his text, the Canon of Medicine, was used in the universities of the world through the sixteenth century.

Avicenna proposed treatments for childhood maladies, including hydrocephalus. He also wrote about and defined levels of intellectual functioning, recognizing that brain injury could affect memory and speech.

Avicenna's view of hydrocephaly is found in a work published in Germany in 1497 entitled Ein Regiment der Jungen Kinder (in Ruhrah, 1925):

Avicenna calls this disease a watery swelling of the head which affects children at times while in the mother's body, however, seldom. ...As long as the fetus is in the mother's body the heat of the mother and the subtilty of the covering of the brain destroy the vapor, which is not the case after the child is born.

It is advised that the wet nurse be cleaned with medicine and be forbidden all irritating food and things which inflate the stomach. Sage in a little sack should be put in the bath and when the child is being bathed it should be placed on the head. It should be bathed fasting and after the bath should be anointed with bitter almond oil and dill oil should be placed up the nostril with a little feather and then the child should be allowed to sleep before it is fed. The wet nurse should be given white lily water or marjoram water and the child should also be given a little to drink. The head should be kept warm. When these things do not help, one should make a plaster out of scrap iron, sarcocol, gum, almonds and white incense and apply it like a cap. If this does not help one should make a broth of garlic corns packed in hot ashes and mixed until it is a white mousse and mix it with a half ounce of incense and lay it on the child for some days so that the head may take its natural form. After that one should make a nasal suppository out of wolf's gall and brains with myrrh and for two months this should be shoved in the nose every eight days while the child is fasting and let it stay for a half hour. (p. 84-85)

The moral conduct of a pregnant woman was frequently suspect in the birth of a mentally retarded child. Ruhrah (1925) records the notes of several writers from the late 1400s that attribute epilepsy to the "desires, either good or bad, of the mother" and "imbecility in the

head of the fetus which originates under the influence of the stars" (p. 86).

The care and treatment of the mentally retarded varied from country to country during the Dark Ages. Since most economies relied on agriculture, the need for manual labor was high and all children became valuable.

A Council at Rouen during the eighth century encouraged women who had children out-of-wedlock to leave them at a church. These infants were cared for and often became serfs on church-owned estates (Scheerenberger, 1983, p.31). Such practices gave rise to foundling asylums, which were built as havens for those children who needed protection or safety.

In 787, Datheus, Archbishop of Milan, founded the first asylum for abandoned infants. Payne (1916) records his declaration:

Now, therefore, I Datheus, for the welfare of my soul and the souls of my associates, do hereby establish in the house that I have bought next to the church, a hospital for foundling children. My wish is that as soon as a child is exposed at the door of the church, it will be received in the hospital and confided to the care of those who will be paid to look after them. (p. 294)

It is interesting to note that the purpose of this institution was for the welfare of Datheus' soul and not the children's.

Children were kept in such asylums and taught a trade and at the age of eight released. Their youth probably gave rise to the practice of calling some of the

mentally retarded "infants of a good God." In certain parts of Europe they were provided free license to roam where they pleased (Krishef, 1983, 18).

In 1150 the concept of "children of God" was changed by an unofficial acceptance of Gratian's Decretum by the Roman Catholic Church. As Durant (1950) notes this writing taught that, "Every human being who is conceived by the coition of a man with a woman is born with original sin, subject to impiety and death, and therefore a child of wrath" (p. 820). "For centuries," writes Scheerenberger (1983), "this concept, which received farther emphasis during the Reformation, produced untold agony among parents of disabled children" (p. 32).

During this same period, it was believed by some that the mentally retarded were connected to the unknown. The sixteenth century astronomer, Tycho Brahe, is said to have kept a retarded companion so he could listen to this person's statements for hidden wisdom.

The mysterious view of the retarded also had a negative side. Throughout Europe religion, politics and superstitions combined to subject countless people to persecution. Witch hunting and the Inquisition reached its full fervor in the middle of the fifteenth century and lasted until the end of the following century (Gail, 1968).

In a work entitled Malleus Maleficarum (The Witches'

Hammer) written in 1487 (Alexander & Selesnich, 1966) all mentally different persons were considered witches. One passage states, "If the patient can be relieved by no drugs, but rather, seems to be aggravated by them, then the disease is caused by the devil" (p. 68).

Deutsch (1946) quotes Samuel Harsnett who wrote in 1599 that those burned as witches had "their brains baited and their fancies distempered with the imaginations and apprehensions of witches, conjurors and fairies and all that lymphatic chimera, I find to be marshalled in one of five ranks: children, fools, women, cowards, sick or black melancholic discomposed wits" (p. 22).

The plight of the mentally retarded did not improve during the Reformation. Kanner (1964) quotes from Dr. Martin Luther's Devine Discourses at his Table, translated by Captain Henry Bell in 1652. Luther saw the feeble-minded as a part of the demonism of the day:

Eight years ago, there was one at Dessau whom I, Martinus Luther, saw and grappled with. He was twelve years old, had the use of his eyes and all his senses, so that one might think that he was a normal child. But he did nothing but gorge himself as much as four peasants or threshers. He ate, defecated and drooled and, if anyone tackled him, he screamed. If things didn't go well, he wept. So I said to the Prince of Anhalt: "If I were the Prince, I should take this child to the Moldau River which flows near Dessau and drown him." But the Prince of Anhalt and the Prince of Saxony, who happened to be present, refused to follow my advice. Thereupon I said: "Well, then the Christians shall order the Lord's Prayer to be said in church and

pray that the dear Lord take the Devil away." This was done daily in Dessau and the changeling died in the following year. Such changelings are merely a mass of flesh, a massa carnis, with no soul. For it is in the Devil's power that he corrupts people who have reason and souls when he possesses them. The Devil sits in such changelings where their soul should have been! (p. 7)

During the various periods of the Middle Ages and Renaissance, mentally retarded persons in rural areas worked with their families in the fields and did the bidding of land owners and nobles. In the Middle Ages the village idiot was common, roaming the countryside while being cared for by neighbors and those who would take him in.

In the cities, the mentally retarded person might have become a laborer, but more than likely was one of the multitude of beggars in Europe at that time. During the Renaissance many of these people were procured for amusement as jesters and buffons by royalty and the wealthy. An example is found in a description of Pope Leo X's dinners. Hibbert (1975) notes, "Dwarfs, buffoons and jesters were nearly always to be found at his table where guests were encouraged to laugh at their antics and at the cruel jokes which were played upon them" (p. 227).

Mentally retarded and mentally ill persons who needed residential care could be found in a variety of institutions including monasteries, hospitals, prisons, almshouses and charitable facilities. Most of these

situations are described in literature as inhumane and deplorable (Abt, 1965; Scheerenberger, 1983; Wilson, 1975).

Henry (1941) notes that the thirteenth century Prussians did not have a benevolent view of the sick and feeble. A portion of their law stated, "Be a man laden with sick women, children, brothers, sisters or domestics, or be he sick himself, then let them be where they lie and we praise him too if he would burn himself or the feeble person" (p. 563).

During this period mental hospitals were built throughout Europe. Mentally retarded persons were surely placed in these facilities because both the mentally ill and mentally retarded were considered victims of intellectual or reasoning deficits. Little differentiation was made between the two groups.

In the thirteenth century, King Edward I of England made an attempt to legally define mental retardation. King Edward II restated this Act after the first version was lost. The King's prerogative (De praerogativa regis, 1325) cited in Hilliard and Kirman (1965) read in part:

The King shall have the custody of the lands of natural fools, taking the profits of them without waste or destruction, and shall find them their necessities, of whose fee soever the lands be holden. And after the death of such idiots, he shall render them to the right heirs; so that by such idiots no alienation shall be made, nor shall heirs be disinherited. (p. 1).

This legislation applied only to a few of the kings subjects because it was oriented to property and land holders, a small portion of the population. The importance of the definition, however, was that it considered the retarded person to be suffering from a congenital condition (idiotia a nativitate) with continuing lack of mental capacity (Hilliard & Kirman, 1965).

Before moving to the seventeenth and eighteenth centuries, note should be made of two exceptions to the squalid residences generally provided for the mentally handicapped in this period.

The literature contains several different accounts of the origin of the Gheel Colony (Byrne, 1869; Carty & Breault, 1967; Dumont & Aldrich, 1962). According to tradition, Dymphna, a daughter of an Irish king, converted to Christianity. The king was incensed by this, so Dymphna fled to Gheel, in Belgium. Her father overtook her, and failing to regain his daughter's affection or disavowal of Christianity he decapitated her.

The legend continues that several lunatics witnessed these acts and were so affected by the cruelty that they regained their senses. This occurrence was hailed as a miracle. Gradually Dymphna's remains became vested with magical significance for the mentally affected. During



the next several hundred years Gheel became a place for pilgrimages of "possessed" patients. As time went on the powers of St. Dymphna attracted so many pilgrims that the town's regular facilities could not accommodate them, and the Gheeloise took the pilgrims into their homes.

For centuries the church directed treatment of the mentally afflicted who came to Gheel. But since 1852, with large increases in numbers of patients, the Colony has been operated by the Belgian government (Carty & Breault, 1967). Though a small hospital was eventually built, the primary mode of care remained family based.

In a book written in 1869, Byrne describes Gheel as she observed it:

Its population numbered 3312 living in 618 houses in Gheel proper. Eight hundred patients were living in these 618 houses.

The patients were treated as members of the families in whose homes they lived. They had their own bedrooms, ate meals with the family, and engaged in all family activities. Many were given responsibilities, such as babysitting and other family chores.

Many were employed in the town and on the farms. If they could handle their own money they were paid for their work, but if they could not, they were given other valuables--tobacco, snuff, eggs, beer, and gingerbread. They could use all community facilities, such as cafes and community halls, were able to attend dances and fairs, and attended all religious ceremonies. Many of them were fond of music, and they were encouraged to play their chosen instruments or listen to selected music. Painting, drawing, and gardening were encouraged, and many patients had gardens of their own. A change of scene was viewed as beneficial, so picnics and other outings were organized. (In Carty

& Breault, 1967)

Others did not find the community as kindly as did Byrne. A Dr. Halliday found in an article entitled "Village of Lunatics" (1848) that it was "not a good curative arrangement, and not a suitable place for those who were highly excited and violent, or who required medical treatment" (p. 222). Esquirol, a prominent physician of the day, reported after an 1821 visit that the most deranged were kept in chains. He saw people whose flesh was scarred by chains and noted iron rings near chimneys and beds with chains attached (Village of Lunatics, 1848, p. 221).

The second exemplary treatment facility of this period was the Mansur hospital in Cairo, built during the late thirteenth century. Henry (1941) notes that each patient had two attendants, and well paid physicians from various parts of the East directed treatment. Each patient had a private room where music was played or reciters read the Koran read. At the time of discharge, each patient was given five pieces of gold to start them on a new life (p. 564).

As in other situations, the Colony at Gheel and the hospital at Cairo were restricted to an elite segment of the population. Most of the mentally retarded during this age did not have such treatment available to them, and were left to struggle and survive on their own.

Conditions in the fourteenth through the sixteenth centuries did not differ greatly from those described above. Little change is noted in the literature until the beginning of the seventeenth century.

### The Seventeenth and Eighteenth Centuries

#### Europe

During the seventeenth and eighteenth centuries, medicine in general made a number of significant advances which would continue to have a role in the study of retardation. Medical care for retarded people per se advanced very slowly and so did attitudes and understanding of mental retardation. Scheerenberger (1983) recounts that in the early 1600s one Alexander Drummond claimed to have cured 40 people of madness, falling evil (epilepsy) and those distracted in their wits. He notes, "After reviewing the case, the court determined that Mr. Drummond should be strangled and burned for being too familiar with Satan. He was!" (p. 42).

The best summary of progress during this period is provided by Philippe Pinel (1806/1962) in A Treatise on Insanity. In the introduction the translator notes that the work is a compilation of the thoughts of that time. He writes, "Though it has not been pursued to its remote

branches, ...it, nevertheless, exhibits the great and badly sketched outlines of a more practical system of nosology than we have yet seen upon the subject" (liv).

Section IV of Pinel's (1806/1962) book divides "mental derangement" into five species or categories:

1. Melancholia, or delirium upon one subject exclusively.
2. Mania without delirium.
3. Mania with delirium.
4. Dementia, or the abolition of the thinking faculty.
5. Ideotism, or obliteration of the intellectual faculties and affections (p. 146).

The fifth category, ideotism, was seen by Pinel (1806/1962) to be the most common, making up the largest group of residents in lunatic asylums. He describes this class as having, "Total or partial obliteration of the intellectual powers and affections: universal torpor: detached, half articulated sounds; or entire absence of speech from want of ideas: in some cases, transient and unmeaning gusts of passion" (p. 172).

Pinel (1806/1962) made his observations first hand as the physician-in-chief at the Bicentre and the Salpetriere during and after the French Revolution. The Bicentre was historically a leprosarium in Paris operated by Vincent de Paul and his associates. In the late 1600s

they housed and cared for missionaries, orphans, novices, seminarians, wayward youth, insane persons, mentally retarded individuals and lepers. Scheerenberger (1983) notes that, "ultimately this facility ... was to provide for the enlightened programming for the mentally retarded of the nineteenth century" (p. 45).

Manceron (1972/1977) described the Bicentre in 1777 as a "receptacle for the vilest, foulest dregs of society" (p. 431). The population included swindlers, defaulters, thieves, vagrants, epileptics, imbeciles, lunatics and the infirm--known as the good poor. They slept six to a bed. There were five or six hundred inmates packed together, a tenth of them dying (Manceron, 1972/1977, p. 432).

La Salpetriere, Manceron, notes, housed only women--7,000 in total. The daily ration for each woman was half a liter of gruel, an ounce of meat and three slices of bread. Of the total population, 1,000 lived in a special wing reserved for those "deprived of their reason." These women are described as:

In the most deplorable conditions when their insanity is the sort that divests them of their instinctive cleanliness. Though the rooms are washed twice a day, these poor souls live in indescribable filth and are like the lowest animals. Madwomen subject to fits of rage are chained like dogs to the door of a kennel and separated from attendants or visitors by a long corridor shielded with grillwork. Food is passed to them through this grillwork, and straw for their bedding. Rakes are used to remove part of the waste that surrounds

them. (Manceron, 1972/1977, p. 431).

Twenty years after this description, Pinel took charge of these two facilities. He argued for changes in operations which would be a radical departure from treatment of that day. Scheerenberger (1983) states, "His greatest contributions, however, involved his perspective of management's responsibilities and organization of a mental hospital. In particular, his contention that brutality and chains and mere supervision should be eliminated" (p. 46). Pinel stressed a treatment oriented approach, humane vigilance, the elimination of physical abuse and chains and employment in various agricultural pursuits. Carlson and Dain (1960) observe, Pinel's approach emphasized the individual's participation in a treatment, program with hope of cure and release.

Pinel's (1806/1962) view of the mentally retarded was not as hopeful as for other classes of patients, but it was still revolutionary. He wrote:

Such are the circumstances characteristic of idiotism. They seldom admit of redress by the best possible superintending police. Humane attention to their physical wants and comforts, in general the utmost that can be devised or done for those unfortunate beings. Their passive obedience and degradation expose them to inattention, and frequently to cruel treatment on the part of the keepers and servants. It is for the governor to be their protector and guardian.

The natural indolence and stupidity of idiots, might in some degree be obviated, by engaging them

in manual occupations, suitable to their respective capacities. With an able active man at their head, idiots are capable of being drilled into any sort of service where bodily strength alone is requisite. The new plantation at Bicentre was made almost altogether at their expense. (pp. 202-203)

Infanticide was no longer considered acceptable to society during the 1600 and 1700s, but the infant mortality rate remained very high and large numbers of infants were abandoned by their parents. Records show that abandoned children were often placed in foundling homes or mental hospitals. Abt (1965) states that of the 2,000 infants placed in the Foundling's Hospital of Paris in 1670, 1500 died within three months. Of the 10,272 infants admitted to the Dublin Foundling Hospital between 1775 and 1796 only 45 survived (pp. 71-81).

Scheerenberger (1983) points out that this era was one in which idiocy and dementia were considered incurable disorders. Many people felt that little could be done and that the mentally ill or mentally retarded person was not really sensitive to pain, hunger, heat or cold (p. 43). This view led to the incarceration of people in the most inhumane situations--asylums and almshouses. Buckmill and Tuke (1968) describe a tour through such a facility in the late 1700s:

As you enter, a creak of bolts, and the clank of chains, are scarcely distinguishable amid the wild chorus of shrieks and sobs which issue from every apartment. The passages are narrow, dark, damp, exhale a noxious effluvia, and are provided with a door at every two or three yards. Your conductor

has the head a visage of a Cherub; carries (fit accompaniment) a whip and bunch of keys, and speaks in harsh monosyllables. The first common room you examine--measuring twelve feet long by seven wide, with a window which does not open--is perhaps for females. Ten of them, with no other covering than a rag round the waist, are chained to the wall, loathsome and hideous; but, when addressed, evidently retaining some of the intelligence, and much of the feeling which, in other days, ennobled their nature. In shame or sorrow, one of them perhaps utters a cry; a blow, which brings the blood from the temple, the tear from the eye,--an additional chain, a gag, and indecent or contemptuous expression, produces silence. And if you ask where these creatures sleep, you are led to a kennel eight feet square, with an unglazed air-hole eight inches in diameter; in this, you are told, five women sleep. The floor is covered, the walls bedaubed, with filth and excrement; no bedding but wet decayed straw is allowed; and the stench is so insupportable, that you turn away and hasten from the scene. (p. 68)

In a facility such as this a friend of William Tuke's died. The family was not informed of her death and it seems were denied information about her status for a long period of time. Incensed by this, Tuke and some members of the Society of Friends established a new institution in which there would be no secrecy. The Retreat, as the facility was called, encouraged family visits and used no chains, hobbles, leg-locks or handcuffs. Occasionally a waistcoat (straight jacket) was used but only for the purpose of preventing harm to a person (Buckmill & Tuke, 1968).

William Tuke used the Retreat's success to call into question management of other asylums. A report in the British and Foreign Medical Review (Buckmill & Tuke,



1968) highlighted problems at the York Asylum. In part the report reads:

Suffice it to mention, that among the instances of mismanagement gradually brought to light, were the most aggravated neglect of all medical and moral treatment. ...False reports, in which especially the deaths were concealed; and, as a grand and appropriate finale, a very strong suspicion of the building itself being willfully set on fire, in the hope of destroying some of the books or patients. (p. 73)

People such as Pinel and Tuke, and the reforms they attempted, are examples of the gradual evolution of more positive social attitudes toward the "mentally afflicted" in Europe. Although a philosophy of humanitarianism would not begin to develop until the middle of the next century, attitudes toward the mentally retarded and new concepts about treatment set a foundation for changes to come. Finally, in summing up this period it must be remembered that the vast majority of people with mental retardation were cared for as part of a family as would continue to be the case in the centuries.

### The Colonies

With the migration to the Western hemisphere, many of the concepts and biases that had developed in Europe about the mentally retarded were transposed to colonial America. The earliest laws governing the people, interestingly, recognized mental retardation. The Massachusetts General Court established The Body of

Liberties in 1641. Section 52 of this code states, "Children, Idiots; Distracted persons, and all that are strangers, or newcomers to our plantation, shall have such allowances and dispensation in any cause whether Criminal or other as religion and reason require" (Eliot, 1910, p. 78). This section was part of the code referring to each man's right to fair legal treatment.

Whether the retarded actually were given the "allowances and dispensations" set forth by the code is uncertain. As Demos (1970) notes egalitarianism was not a common theme in seventeenth century Puritan society. If a child, for instance, cursed or struck his/her parents or was "stubborn or rebellious" the law provided that he/she could be put to death by the courts. Apparently few cases reached the courts, but one noted in 1679 is of particular interest.

Plymouth Colony Records show that, "Edward Bumpus for striking and abusing his parents, was whipt at the post; his punishment was alleviated in regard he was crasey brained, otherwise he had bine put to death or otherwise sharply punished" (Demos, 1970, p. 102).

While flogging and shaming in the public stocks were relatively common it is not likely that many mentally retarded people were subjected to these punishments. A more common form of "treatment" was banishment. A person was encouraged to leave a town, preventing the

possibility that she or he would become a public charge. Krishef (1983) adds, "Another method of dealing with the retarded during these times was to kidnap them during the night and remove them to the outskirts of some other town" (p. 20). By using this method officials hoped that the person might be cared for in the new town.

Not just the town, but town officials were charged with the duty of maintaining the retarded in their homes. Deutsch (1946) records that the commissioners of Surrey County, Virginia, contracted with Robert House to board John Deanne, an "Iddiott" and to provide him food and clothing. The records also indicated that in 1662 Deanne worked for part of his keep and is referred to as "servant to his master, Mr. House" (p. 48).

During the late 1600s the Colonies developed an extreme interest in witchcraft. There is evidence that mentally retarded people were among those accused in Salem in 1692. During that year, 20 people were put to death, 55 others confessed to being witches and 150 were waiting trial when Governor Phigs dismissed the Puritan court. Erickson (1966) describes some of the prisoners as "witless persons whith scarcely a clue as to what happened to them" (p. 145).

Immigration increased rapidly during the first half of the next century. One common way of coming to America during this period was through indenture contracts and

many who came this way, Scheerenberger (1983) notes, were mentally retarded (p. 94). Unfortunately, in the colonial climate of the 1700s self-reliance and strength were traits to be admired. Those who were dependent and weak were given little respect.

Sections of the Elizabethan Poor Law of 1601 were the basis of colonial social programs. Relief to the poor was seen as a family and local responsibility. The public poor were supplemented by church and private charity and frontier neighborliness (Adams, 1976-1978).

As in Europe, the mentally retarded were grouped with other types of people. Deutsch (1946) notes, "Sick poor, old poor, able-bodied poor, infant poor, insane and feeble-minded--all were grouped under the same stigmatizing label, 'paupers,' and all were treated the same way" (p. 116). The retarded in the 1700s were viewed as inferior and were treated with considerable contempt.

Although the first almshouse was built in Boston in 1660, it was not until 1752 that the Pennsylvania Hospital established a separate section for the mentally ill and mentally retarded. Scheerenberger (1983) notes that by 1756 the cellar had been set aside for the mentally affected and that orders had been placed with a local blacksmith for leg locks, handcuffs and chains (p. 95).

In 1773, after seven years of debate, Virginia opened the first hospital solely for the mentally ill and mentally retarded. The purpose of the hospital was to "make provision for the support and maintenance of Ideots, Lunatics and other persons of unsound Minds." No similar facility was built for a period of fifty years until the Eastern Lunatic Asylum was opened in Lexington, Kentucky (Deutsch, 1946, pp. 70-71).

In summary, the care and treatment of the mentally retarded in the seventeenth and eighteenth centuries in America was a reflection of European developments. Many of the same attitudes and biases about the retarded came across the Atlantic with immigrants to the continent. For the greater part of this period care for the retarded was a familial and local responsibility. As towns and villages grew into cities, institutions began to be built to care for the class of people known as paupers--the poor, sick, insane and mentally retarded.

### The Nineteenth Century

During the 1800s much progress was made in developing an understanding of mental retardation. Many forms of retardation were identified and links to various general medical conditions began to be established. For example, the relationship of hypothyroidism to cretinism was established by mid-century. Other medical advances

began in this century, but would be developed in the 1900s, as technology allowed for more advanced diagnosis. Major changes in the nineteenth century were more directed toward shifts in attitudes and perspectives on mental retardation.

### Europe

Many of the refinements in treatment and care of the mentally retarded which began in Europe in the 1800s would play an integral part in development of services for the retarded in the United States.

Some of the first changes were in the classification of mental retardation. Esquirol (1845/1965) in his Mental Maladies: A Treatise on Insanity divided mental retardation into two levels. He wrote, "We may class idiots in two series, in which they may all be included. The former embraces imbeciles; the latter, idiots properly so called" (p. 448).

Imbeciles were defined as the idiotic people who had some use of their intellectual functions. Esquirol stated, "Whatever education they may receive, imbeciles never reach the degree of reason ... to which their age, education and social relations, would otherwise enable them to attain" (p. 448). He continued his description by noting that everything they attempted was imperfect and they were usually timid, cowardly and obedient.

On the other hand, idiots, Esquirol writes, have no ideas and have nothing to desire. He classes them below farm animals. He says, "They have neither pain or pleasure; hatred nor love. They are untimely births. They are monsters, and doomed to an immediate death unless the tenderness of parents or public commiseration preserve them" (pp. 467-468).

The significance of Esquirol's work was that it began to provide some uniform terminology. Interestingly, this terminology was comparative and provided a social definition based upon the subject's abilities in relation to others (Tyor & Bell, 1984, p. 7). As will be seen, this was the basis for the definition of mental retardation for years to come. Esquirol's successors would expand upon this terminology and continue to broaden the concepts of mental retardation.

Edouard Seguin (1866) divided idiocy into four categories: idiocy, imbecility, backwardness or feeblemindedness and simpleness. He said, "The idiot moves, feels, understands, wills, but imperfectly; he does nothing, thinks of nothing, cares for nothing, he is a minor legally irresponsible, isolated, without association, a soul shut up in imperfect organs and innocent" (in Scheerenberger, 1983, p. 55). Despite this rather bleak definition, Seguin was to become a leader in the education, care and treatment of the mentally

retarded. He believed that the education of the mentally deficient could be enhanced by emphasizing the development of the sense organs. He developed a program of sensorimotor training that stressed the full utilization of a person's senses. In 1848, Seguin emigrated to the United States and, as will be discussed, played a major role in the development of American programs.

Many other Europeans contributed to the base of knowledge about mental retardation during this period. Duncan and Millard (1866) wrote a manual of instruction for the training of the retarded. Ireland (1887) wrote the first comprehensive text on mental retardation, addressing topics such as incidence, definition, education and the law. Down (1887) authored a work that used ethnic categories of classification rather than the labels of the day. This book also discussed the causes and methods of prevention of mental retardation.

These works typify medical thought about mental retardation in late nineteenth century Europe. Such thinking carried over into the provisions made for the care of mentally retarded persons, as well.

Scheerenberger (1983) notes that in nineteenth century western Europe, life became increasingly harsh for the mentally retarded as urban areas expanded and the industrial movement grew. Those who could not get



accepted into apprentice programs or find work in industrial settings frequently became beggars or thieves. Wealthier families kept their children at home, often hidden from view (p. 65).

Government was also increasing its responsibilities to dependent children. In 1811, Napoleon issued a decree concerning foundlings, abandoned children and poor orphans. These children were to be cared for in hospitals or boarded with farmers, after the age of six. Guardianship responsibility was given to a member of the "children's commission" who was charged with placement into apprentice positions when the child was twelve. For those who could not be placed, "the crippled and the infirm," the hospital was to keep them and establish workshops to provide them employment (Payne, 1916, pp. 342-345). Scheerenberger (1983) adds that by 1838 all such institutions were directly supervised by the French government (p. 66).

In England various laws were enacted throughout the nineteenth century to better provide for idiots and imbeciles. The 1834 amendment to the Poor Law, for example, provided that dangerous lunatics, insane persons or idiots could not be detained in workhouses for more than 14 days unless a physician certified that this was in order. The Lunatic Asylums Act of 1853 ordered each county to provide care for all lunatics, including "every

person of unsound mind and every person being an idiot." The Idiots Act of 1886 made provision for asylums to care for, educate and train individuals classified as idiots and imbeciles "from birth or from an early age" (Hilliard & Kirman, 1965, pp. 2-3).

During the first half of the nineteenth century, even with the new laws and acts, the quality of care in hospitals did not improve greatly. Henry Burdett (1880, 1891) visited hospitals throughout Europe and wrote about their management near the end of the century. At a hospital in Italy he observed:

Although lunatics are excluded by statute from this establishment, a goodly number seem to have been admitted in the first stage of the disease. These patients are reported as rendering a good profit to the institution and of affording as much trouble and annoyance to the medical director. (1880, p. 59)

In Hospitals and Asylums of the World Burdett (1891) reported on common practices of the day for the treatment of lunatics. He wrote, "Some were fastened to the wall by a chain a foot and one-half long, this method was extolled as being peculiarly calming. Chains were universally preferred to straight-waist coats, because they were less expensive" (p. 61). Lunatics who stayed in these hospitals for long periods of times were seen as incurables and probably were mentally retarded.

Although many individuals such as Saegert, Voisin, Buckmill, Weise and Montessori (Krishef, 1983;

Scheerenberger, 1983) contributed immensely to ideas about the care and treatment of mentally retarded people in Europe, three deserve a brief note because of their subsequent influence on American programs and services.

Jean Marc Gaspard Itard was the chief medical officer of the National Institution for the Deaf and Dumb in Paris. In 1799 the Minister of Champagny ordered the wild boy of Aveyron sent to the Institute because he thought him to be an important case for the study of man (Malson, 1964/1972). Itard decided to try to educate the boy, whom he named Victor. This decision made him, and his work of attempting to teach deaf-mutes to speak, famous throughout Europe.

Itard (1907/1962) described Victor as follows: "He was destitute of memory, of judgment, or aptitude for imitating, ...of all means of communication. He passed rapidly and without any apparent motive from apathetic melancholy to the most immoderate peals of laughter. He was insensible to every kind of moral influence" (p. 6). Itard noted that most who saw the boy "judged him fit to be sent to an asylum." He added, "As if society had the right to tear a child away from an innocent life and send him to die of boredom in an institution" (p. 11).

After two long years of instruction the boy appeared relatively normal in limited areas. At the end of five years of training, it appeared to Itard that he had made

only slight progress and was not going to be able to train the boy to have more than limited speech, limited use of sensory skills and no reliable skill in handling his emotions.

It was at this point Itard ceased his work with Victor. He wrote of his success and failure and concluded with a statement of why such care and treatment was important to children like Victor. He wrote:

My Lord, looking at this long experiment from any point of view, whether it be considered as the methodical education of a savage or as no more than the physical and moral treatment of one of those creatures ill-favored of nature, rejected by society and abandoned by medicine, the care that has been taken and ought still to be taken of him, the changes that have taken place and those which can be hoped for, the voice of humanity, the interest inspired by such a complete desertion and destiny so strange--all these things recommend this extraordinary young man to the attention of scientists, to the solicitude of our administrators, and to the protection of the Government. (p. 101)

From this initial work came an interest in nineteenth century Europe in the problems of educating the mentally retarded. One of Itard's students (and a student of Esquirol), Edouard Seguin noted in 1886 that Itard was, "the first to educate an idiot with a philosophical object and by physiological means" (p. 28).

Seguin joined the methodologies of Itard with the theories of Esquirol to become the first professional to specialize in the treatment of mental defectives. A physician, Seguin started a private school for mentally

retarded children in 1837. In 1842 he became the medical officer for the Bicentre in France, an institution with a long history of inmate degradation. Here he worked with the mentally retarded and wrote several pamphlets on training techniques.

Tyor and Bell (1984) observed that Seguin constantly searched to improve the theoretical foundations of training the retarded. He selectively employed instructional techniques used by teachers of the deaf. He stressed the importance of individualized treatment based on thorough diagnosis carried out in a well planned environment.

Seguin believed that every retarded individual, no matter how severely affected, exhibited some activity that could be discovered and cultivated. In his training he used exercise for strengthening the body and correcting physical problems, and special diets to assist physical and mental function. The establishment of relationships, making choices and judgements was also critical to Seguin's system (Seguin, 1866, p. 133-209).

In addition to the activities of the educational process, Seguin believed that moral treatment was critical to the mentally retarded person's development. He emphasized the curative potential of a strong, positive relationship between master and pupil. Moral treatment to Seguin, and other nineteenth century practitioners, meant treatment that was rarely physical.

The phrase is often used synonymously with humanitarian, non-restraint and tenderness (Kraft, 1961, p. 401).

Kraft (1961) writes, "Perhaps the basic element in Seguin's concept on moral treatment was his reliance on a general spirit of love which was to animate all contacts between educator and idiot" (p. 403). Seguin demanded that all persons, from physicians to cooks, who came in contact with the mentally retarded treat them "morally." It must be remembered that he was saying this about a class of people who traditionally were seen as unlovable and beyond the rejuvenative efforts of human warmth.

Seguin's theories and influence carried on for many years, not only in Europe but also in the United States. In 1848, revolution came to France. Fearing that social and political conditions would not improve, Seguin emigrated to the United States. For over thirty years he shaped the systems of care and treatment for people who were mentally retarded in this country.

Finally, Swiss physician Johann Jacob Guggenbuhl (1816-1863), should be mentioned. Guggenbuhl devoted his life to the treatment of cretinism, which he saw as a form of mental deficiency. As a young physician he could not accept the traditional viewpoint that idiotic children were unteachable and centered his work on the cure and prophylaxis of cretinism. After a number of

years in private practice, he concluded that residential care for such individuals was critical.

He was given 40 acres of land in Switzerland. The land was at an elevation of more than 4000 feet which was important because it was thought that cretinism was more abundant in the valley and was not known to occur at higher elevations. At this site, called the Abendberg, Guggenbuhl opened his institution in 1842, the first residential facility solely for the mentally retarded.

Guggenbuhl believed that the residents of the Abendberg could be cured with proper diet, bodily care, exercise of sensory organs and habituation. His work was soon hailed as having significance for all feeble-minded children. Guggenbuhl became entrepreneurial in his efforts, traveling extensively and publicizing the Abendberg. As Kanner (1964) notes, "He did not hesitate to solicit endorsements from notables whom he knew to be favorably disposed, nor did he refrain from including their eulogies in his communications" (p. 24).

Guggenbuhl was widely honored for his achievements. One visitor summarized the perceptions of the institution as follows:

It is, in truth, a noble and exalted idea that, through human exertions, a mind may be awakened in what was apparently a senseless mass, and that even education may be extended to those who have been hitherto considered beyond the reach of instruction and incapable of intercourse with their fellow creatures. And what a brighter and more glorious page can there be in the history of Switzerland if a

century hence it should be recorded that all Europe helped to exterminate cretinism. (Kanner, 1964, p. 26)

In the 1850s Abendberg's fame began to falter. Unfortunately, Guggenbuhl's success led to his downfall. As Guggenbuhl traveled, he left the supervision of Abendberg to others, resulting in deterioration of the facility. Critics began to push for proof that Guggenbuhl had actually cured cretins. No such proof existed.

In April of 1858, a government investigation of the institution found many problems. The investigative report acknowledged that Guggenbuhl had begun the project with proper intentions, but that these were soon adulterated by vanity. The report went on to state that all criticism was met with the air of a misunderstood martyr for a holy cause and treatment results were being embellished (Kanner, 1964, p. 29).

Guggenbuhl was labeled as an embezzler, quack and swindler. He died in 1863, three years before the Abendberg finally closed.

In summary, nineteenth century Europe provided a transitional period in the development of thoughts and methods related to the care and treatment of mentally retarded people. Although many participated in this transition, three stand out. Itand showed the world that the education of idiots and imbeciles was within the



realm of possibility. Seguin developed and expanded the methods of teaching this group of people. Guggenbuhl originated the idea of residential training for the mentally retarded.

In a letter to the Association of Superintendents of Idiot Asylums meeting at Syracuse in 1886, Millard captures much of the late nineteenth century European view about the mentally retarded. He wrote:

The success thus far granted to the existing idiot asylums is truly gratifying. We well know that idiots cannot be properly trained or cared for at the homes of the poor, as parents cannot spare the time and do not possess the requisite knowledge. Nor should they be placed in lunatic asylums, where, being credulous, they are bewildered by the strange talk of the insane; being imitative, they are prone to copy any wild antics of lunatics; and, being more or less timid, are alarmed by the ravings of maniacs.

In an idiot asylum there is more to be done for them than can be accomplished, each case needing to be individually studied, and sometimes individually dealt with. When the late Dr. Guggenbuhl carried on his work efficiently at the Abendberg, he employed a Sister of Mercy for every three pupils, besides having a skilled male teacher. Idiots require to be taught to be cleanly in their habits, to wash and dress themselves, to use a spoon, and afterwards a knife and fork. Speech as to be evoked or improved, their senses to be aroused, the use of their limbs, and especially the use of their fingers, to be developed; their faculties of attention and imitation to be cultivated; elementary instruction to be imparted in an interesting manner, without producing weariness, the teacher's mind dropping, as it were, into the minds of the pupils; good manners have to be engendered and bad habits counteracted. Their confidence has to be won by kindness, and their wills can be guided by tact and firmness; their moral and religious sense has to be awakened, and some Scriptural knowledge to be conveyed, so as to excite, with God's help, simple faith in him as

their Father, Jesus as their Savior, and heaven as their home.

Imagination depicts your excellent asylums, with their liberal dietaries, well-ventilated school-rooms, day-rooms, and dormitories, dining-halls, work-shops, skillfully-adapted gymnasiums and spacious recreation-grounds, all being characterized by cleanliness, cheerfulness, comfort, and order. May your mottos still be "onwards," and with God's blessing, such progress be made that at length all idiots and imbeciles in the United States may be received into a training school or custodial home. (pp. 3-4)

Although all idiots and imbeciles in the United States were never to be received into training schools and custodial homes, the other concepts mentioned by Millard did become general practice in the United States. As shall be seen, care and treatment for the mentally retarded in the United States descended directly from European beginnings.

#### The United States

The early portion of the nineteenth century in America centered around forming a political nation and shifting from an agrarian to industrial society. Very little was done for the mentally retarded or other impoverished groups during the first two decades of the century. Education was primarily in the hands of the church and private individuals. Care for the poor and indigent remained a local burden. As Scheerenberger (1983) notes, "Many of the traditional ways of resolving problems of the poor and mentally affected people that

had been developed during the preceding two centuries were reconfirmed during the early years of the nineteenth" (p. 99).

Mentally retarded people born into more wealthy families were attended at home. Those not so well-to-do were treated under the poor laws of the locale in which they lived. Paupers were not considered in a positive light in most communities. Friedman (1974) says, "Communities resented him and the money they had to pay for his support. Consequently, the poor laws were punitive. They were meant to deter, to make poverty unpalatable, to make relief come bitter and dear" (p. 189).

One system used by local governments to assist the poor in the 1820s was called outdoor relief. This was financial support given to families and relatives to retain the individual in their home. Such support was contrasted with what came to be called "indoor relief" or institutional care. Friedman (1974) notes that this latter form became the "treatment" of choice in many areas in the late 1820s. The almshouse or poor house was seen as a more efficient place to give moral education and to put the poor to work. Best of all, it would save government money.

Other authorities used the "bidding-off" system in an attempt to keep costs down. Indiana law, for example,

allowed that all persons who had become public charges were to be farmed out at public auction. The law stated that the auction would take place "on the first Monday in May, yearly and every year, at some public place" and the poor would be given "to the person or persons, who shall appear to be lowest bidder" (Friedman, 1974, p. 190). The successful bidder was paid a sum by the town to keep the poor for that year and the lower the sum the better.

It was also understood that the successful bidder was entitled to as much as work as he could extract from the people. Deutsch (1946) adds, "The insane and the feeble-minded are often most eagerly sought, for strong backs and weak minds make good farm laborers--and the bidders are invariably farmers" (p. 118).

As the country continued to grow, so did the pauper class. A New York state report recorded a total of 22,111 paupers in 1822. Of this number 446 were idiots and lunatics, 287 were blind, 928 were extremely aged, 797 were lame, 2604 were children under the age of 14 and 1,585 were "reduced to that state by the excessive use of ardent spirits." The remainder were capable of working and earning \$150,000 annually for the state. Costs, however, had risen dramatically, far exceeding the revenue produced. In 1815 the cost was \$245,000; in 1819, \$368,645; and in 1822, \$470,000 (Breckinridge, 1938, pp. 40-43).

Existing systems of relief of chronic pauperism did not appear to meet the increased need for care. Some critics were concerned that medicine was failing to provide a cure for paupersism. Deutsch (1946) observes:

The pattern of poor relief was still loose and multi-colored, but the threads were gradually being drawn together in one direction. The general trend was leading inexorably to institutionalization--toward the poorhouse. The young nation was growing rapidly: new and thriving centers of population were springing up. The old, haphazard ways of communal life, suitable enough for the rough patchwork existence of a pioneer people, were proving vexatious and inadequate in the settled areas. Closer population groupings demanded greater centralization and uniformity in the operation of social services. (p. 121)

The result was establishment of almshouses and poor farms. In 1824, New York passed a comprehensive act to establish county poorhouses. Friedman (1974) writes, "This act, a historic step, established the principle of indoor relief; it made the county poorhouse the center of the public relief system" (p. 191). By 1830, nearly every state government had encouraged the construction of such facilities, and by so doing had given tacit approval to the future development of institutions for the feeble-minded.

The 1820s, the period of poorhouse planning and building, had hardly passed when some observers began to realize that attempting to house the entire pauper class in such facilities created its own problems. An

institution admitting all ages of paupers covering the full range of mental and physical health could not address the needs of any one group, let alone all of them.

Quality of life for the mentally retarded was not improved by these new facilities. In fact, accounts indicate that conditions became very similar to those described in seventeenth and eighteenth century Europe. The miserable care provided in almshouses and jails became a focal point of the changes advocated by Dorothea Dix in the 1840s and 1850s.

Although known historically as a mental health reformer, Dix worked on behalf of many groups of people who found themselves in deplorable living situations. In her Memorial to the Legislature of Massachusetts, Dix (1843) highlights the plight of some of the mentally retarded of the day. She wrote:

The case of one simple boy is peculiarly hard. December 6, 1841, he was admitted to the house of correction, East Cambridge, from Charlestown as an Insane or Idiotic boy. He was unoffending, and competent to perform a variety of light labors under direction, and was often allowed a good deal of freedom in the open air. September 6, 1842, he was directed to pull some weeds, (which indulgence his harmless disposition permitted) without the prison walls, merely, I believe, for the sake of giving him a little employment. He escaped, it was thought, rather through sudden waywardness than any distinct purpose. From that time nothing was heard of him till in the latter part of December, while at Ipswich, in the common room, occupied by a portion of the lunatics not furiously mad, I heard some one say, "I know her, I know her," and with a joyous

laugh John hastened towards me. "I'm so glad to see you! So glad to see you! I can't stay here long; I want to go out," &c. It seems he had wandered to Salem and was committed as as an Insane or Idiot boy. I cannot assert that most of the Idiotic subjects in the prisons in Massachusetts are unjustly committed, being wholly incapable of doing harm, and none manifesting any disposition either to injure others or to exercise mischievous propensities. I ask an investigation into this subject for the sake of many whose association with prisoners and criminals, and also with persons in almost every stage of insanity, is as useless and unnecessary, as it is cruel and ill-judged. If it were proper, I might place into your hands a volume, rather than a page, illustrating these premises. (pp. 501-502)

In this report, Dix listed many other examples from her journals and notebooks. These included idiots being chained, closed in a stall for 17 years, never being removed from a room, confined to jail and other "miserable and wretched" conditions. She urged the legislature to "devise a remedy for the evils now attending the unfortunate pauper lunatic and idiot" (Dix, 1843).

Dix traveled constantly and made pleas before numerous state legislatures in behalf of the mentally ill and mentally retarded. Her approach was that states, and not cities and counties, should be responsible for establishing institutions.

Institutional care, it should be noted, was the preferred form of treatment for the mentally retarded according to Dix. In 1846, in a review of resources in Kentucky she stated that the association of idiots with

other children had injurious influences. She continued, "But I think there can arise no question as to the greater fitness of gathering these often helpless creatures into an asylum in which they may be surrounded with every needed care" (pp. 3-4).

Dix (1846) contended that the money paid out by the state of Kentucky for the maintenance of idiots in family homes for two years could build a "spacious and comfortable asylum." She argued that after construction the cost to the state would be much less than the practice of boarding idiots with private families.

In addition to the influences on the non-idiotic children in the family, Dix believed the mentally retarded should be removed from their families for other reasons. These were related to her views regarding the causes of retardation. She believed mental deficiency was due to the "intemperance of parents" (1846, p. 4), the "wickedness and ill consequences of the intermarriage of blood relations" (1852, p. 10) and the "influx of foreigners" (1847, p. 5). Because of these influences, Dix felt strongly that mentally retarded children should be cared for in institutions.

Dix wanted to make her concepts for care and treatment a national standard. In 1848, she addressed the Senate of the 30th Congress of the United States, asking that five million acres of land be set aside for



the construction of institutions and accompanying farms for the mentally ill, epileptic and mentally retarded people. She argued that people in all 30 states were affected and that as "religious, social, civil and revolutionary excitements" continued, "this terrible malady would continue fearfully to increase" (Dix, 1848, p. 2).

Dix (1848) concluded her request to Congress asking them to "assure the greatest benefits to all who are in circumstances of extreme necessity, and who, through the providence of God, are wards of the nation, claimants on the sympathy and care of the public" (p. 32). Congress passed this bill in 1854, but it was vetoed by President Franklin Pierce. He did so because he believed such an act would transfer to the federal government the charge of all the poor in all of the states (Deutsch, 1946, p. 178).

As an aside and in retrospect, (history having revealed the outcomes of setting aside lands for other groups in the nation, i.e., the American Indians) it is significant that Pierce did veto the legislation. Had he not struck down this proposal the course of care and treatment for the mentally retarded in the United States might have been vastly different.

A contemporary of Dix was Samuel Gridley Howe. Howe was a physician, trained at Harvard, who spent much time

in Europe. In 1832, Howe became the first director for an asylum for the blind in Boston, which became known as the Perkins Institute and Massachusetts School for the Blind. In the 1840s Howe worked with Horace Mann to force reforms in Boston's school system. Throughout the course of his life he was involved with the Greek revolution, the anti-slavery movement, prison reform, public charities and debate about annexation of countries such as Santo Domingo (Sanborn, 1891).

Howe's work with the mentally retarded began in 1839 when he accepted a blind idiot into the Perkins school because he had a theory that "loss of certain senses was connected with a general weakening of the mental powers, sometimes with actual idiocy" (Sanborn, 1891, p. 168). Having only limited success Howe determined that Perkins could not accept any children below normal intelligence because of the adverse effect on the other children. He recommended that an asylum for the feeble-minded be built on the grounds of Perkins. In 1840, he wrote in his annual report that sooner or later something would have to be done for this group of children (Schwartz, 1956).

As has been alluded to previously, the general tendency of society during this era was to confound indigency with other social problems. In 1835, the General Court (legislature) of Massachusetts directed that the indigent insane be removed from the State

Lunatic Hospital and be "placed in the jails or house of correction." Also, in making a decision about which lunatics to remove, the law allowed "in all cases, when other circumstances were equal, the selection of foreigners before citizens" (Balasalle, 1980, pp. 50-51).

Howe fought against the trend of locking away the indigent insane (which included the mentally retarded). In an article in the Boston Advertiser in March, 1845, he wrote:

Christianity demands that in the great march of civilization, the rear rank should never be left too far behind; that none should be allowed to perish in their helplessness; but that the strong should help the weak, so that the whole should advance as a band of brethern. (Schwartz, 1956, p. 138)

In 1846, Howe convinced the Massachusetts General Court to establish a committee to examine the condition of the feeble-minded in the commonwealth, to ascertain their number and whether anything might be done for their relief. Howe sent out circulars to every town clerk, traveled to over 60 cities and towns and personally examined 574 individuals "who were condemned to hopeless idiocy, who are considered and treated as idiots by their neighbors and left to their own brutishness" (Richards, 1909, p. 206).

The committee's report to the legislature was written by Howe in 1846 (Richards, 1909). He called for action to be taken by the State based on five basic

premises which he believed to be available to all. First, Massachusetts gave the right to an education to all citizens. Should she neglect "the poor idiots, the most wretched of all born to her?" Second, other countries had shown that training improved the plight of idiots. He argued, "And can the men of other countries do more than we?" Third, benefits of education would improve the bodily and mental condition of idiots and; Fourth, "all the others in the State would be indirectly benefited." Finally, the commonwealth could demonstrate to the country "that the young can be trained to industry, order and self-respect; that they can be redeemed from odious and filthy habits" (pp. 208-210).

As a result of this appeal, the legislature provided \$2,500 a year for a three year experimental school for ten idiotic children. On October 1, 1848, a wing of the Perkins school was opened as the first public institution for the mentally retarded in the United States.

Before the experimental school accepted its first students, a private institution for the mentally retarded began operation in Barre, Massachusetts. This school was in the home of Dr. Hervey Wilbur. He had been impressed by the work of Seguin, entitled Traitement moral, hygiene et education des idiots et des autres enfants arrieres and applied the techniques to a few children of wealthy parents (Scheerenberger, 1983, p.253).

Wilbur's facility operated on a family model, with staff and residents living and eating together. Graney (1979) found that Wilbur thought programs for the mentally retarded should contain four elements. They were meant to be "(a) specialized, and primarily educational programs (for children) following Seguin's physiological method, (b) small (<250 persons), (c) home-like settings, and (d) based upon the philosophy of "moral treatment" (p. 4). Similar principles guided all institutional development during the mid-nineteenth century.

These early proponents of institutions believed that through education and training, the mentally retarded could lead more normal lives in society. As Wolfensberger (1975) notes, the purpose was not to reverse or cure retardation, but to diminish the intellectual impairment and increase adaptive and compensatory skills of the pupils (p. 24).

Kuhlman (1940) inaccurately stated the purpose of the early institution. He wrote, "The professed object of the State School was to bring the mental defectives back to normal by a special form of training, and after a few years return him to his home or community" (p. 9). This was not the intent. Wilbur (1879) wrote:

We do not propose to bring all grades of idiocy to the same standard of development or discipline; nor to make them all capable of sustaining, creditably,

all the relations of a social and moral life; but rather to give to dormant faculties the greatest practicable development, and to apply those awakened faculties to a useful purpose under the control of an aroused and disciplined will. (p. 31)

The institution was seen as a temporary boarding school. The early founders did not want their schools to be considered asylums. Johnson (1899) notes admission was restricted to these classed as improvables, a term which meant the person could, at some point, be returned home and to public schools (p. 465).

Howe practiced this philosophy. By 1869, eighteen years after he had opened the school, there were only 87 students living at the facility. During the twenty years of operation, Raymond (1948) reports 465 children had been admitted and 365 had been discharged to the community (p. 84).

Initially, training of the mentally retarded was seen as a right of all citizens and a duty of society, not a charity. The founders of the early institutions made this their focal argument, although not always successfully. Raymond (1948) comments, "There was a constant struggle to overcome the indifference and antagonism of the legislature in Massachusetts" (p. 82). In order to get an appropriation for an experimental school in New York, five years of "agitation of the question was kept up" until legislation was passed in 1851 (Johnson, 1899, p. 472).

The first half of the nineteenth century in the United States was an era that signaled the start of significant changes in the care and treatment for the mentally retarded. The specialized institution had been established. This was a departure from the individualized care fostered by small parochial communities which were rapidly growing into large cities. As the population grew, costs increased and governments began to rely more and more on external institutional settings.

These institutions were intended to perform educational functions for pupils, their parents and society at large. The early superintendents believed that increased attention to treatment of defects was indicative of the progress of civilization. According to Tyor and Bell (1984), "America was becoming a fine and better society because it no longer abandoned the handicapped to lives of emptiness and misery" (p. 19).

By the 1880s this view would change. The small, homelike educational school would be replaced by the large, crowded, poorly financed institution.

Changes took place for a series of reasons. First, education of the mentally retarded became a predicament for those running the schools. Favorable public opinion was important to continued existence--especially for the experimental programs. It was widely held that idiots

had no minds and could not benefit from education. To counteract such generalizations, the reports of superintendents stressed that while idiocy was not a disease to be cured, it was a condition that could be improved. Yet, claims for dramatic improvement misled observers to expect ultimate recoveries. The task before superintendents was to deflate unrealistic hopes while maintaining claims of positive accomplishments.

It should be noted that among the observers of these actions were legislators who funded such projects. At this time institutions were built near state capitols. For example, the first facility in New York was "on the Troy road, about two miles from the capitol" ("Reports of Institutions for Idiots," 1852, p. 28). In Kentucky, Stewart (1882) reported, "It is only a short walk from the city of Frankfort, and the members of the Legislature can make themselves familiar with everything necessary for its successful management" (p. 269).

The commissioners of the Kentucky institutions in 1866 attempted to strike an appropriate balance. They wrote:

Indeed, it cannot be reasonably expected to educate any of them to such a degree as they can become professional men, or procure a livelihood by literary pursuits. Yet there are many of them who can be taught, with comparative ease, some of the simpler mechanical arts, and thus have made useful to themselves as well as society. (Tyor & Bell, 1984, p. 27)



A second dilemma was what to do with the people who attained legally established age limits. Many of the residents literally had no place to go and the options of placement in almshouses or county farms seemed counter-productive. In reviewing this development Fernald (1893) noted that it was not expedient to return some people to the community. He wrote:

A large number, as a result of the school discipline and training, could be taken home where they became comparatively harmless and unobjectionable members of the family, capable, and under the loving and watchful care of their friends, of earning by their labor as much as it cost to maintain them. But in many cases the guardians of these children were unwilling to remove them from the institution, and begged that they might be allowed to remain where they could be made happy and kept from harm. It was neither wise nor humane to turn these boys and girls out to shift for themselves. The placing of these feeble-minded persons always proved unsatisfactory. Even those who had suitable homes and friends able and willing to become responsible for them, by the death of these relatives were thrown on their own resources and drifted into pauperism and crime. It gradually became evident that a certain number of these higher-grade cases needed life-long care and supervision, and that there was no suitable provision for this permanent custody outside these special institutions. (p. 210)

Eventually, upper age limits were eliminated due to unavailability of family living situations, jobs or other forms of community support. Scheerenberger (1983) notes that in the last quarter of the nineteenth century further support for the retention of adults in institutions resulted from negative attitudes toward mentally retarded people, especially women (p. 124).

A third dilemma was related to the procreation of mentally retarded people. Dr. George Knight in the President's Address given to the medical officers of institutions in 1888 noted New York's progressive work to limit mentally retarded women from "reproducing their own kind." New York, he said,

had taken a step forward whose influence, even considered simply as preventive measure, we cannot overestimate; for we owe it not only to the adult imbecile herself, but to humanity and the world at large, to guard in every possible way against the abuse and increase of this class. (p. 52)

The links between heredity and mental retardation would continue to be developed over the coming decades and become justification for many institutional placements.

The fourth dilemma faced by superintendents was what to do with the more severely affected population. The original schools only took children they felt they could educate. Over time the institutions began to take the more severely involved children and were divided into two units--the school section and the custodial section.

In 1888, Dr. Kerlin reported that two new buildings at the Pennsylvania Training School had been built, known as Hillside A and B. These constituted the asylum branch and "sheltered two hundred and thirty inmates, three-fourths of whom are of the most defective and dependent class." He reported that this unit had reduced costs and taken care of "the problem as to the care of the so-

called custodial element" (p. 79). He concluded by stating:

In short, the experience at Elwyn attests to the economy, reasonableness, and humanity of embracing under the central administration of a general institution all the grades and classes of the idiotic and feeble-minded, living in segregate buildings, it is true, but allowed legitimate contact; each divisible from the other by a classification scientific but not rigid, yet no one group isolated from the Divine influences of hope and the human helps to improvement. (pp. 80-81)

The issues which confronted the administrators of institutions during the latter part of the 1800s--educational problems, upper age limits, segregation of populations and custodial care--greatly changed the operation of institutions. The institution was no longer a small, experimental school serving a select group of mentally retarded people. As White and Wolfensberger (1969) note, "As non-rehabilitated residents accumulated, the objective of the residential programs changed to one of protection" (p. 5).

Changes in attitudes, philosophy and governmental practices resulted in an enormous shift in services offered by the institutions. Governor Bulter of Massachusetts reportedly said, "Give them an asylum, with good and kind treatment; but not a school. A well-fed, well-cared for idiot, is a happy creature. An idiot awakened to his condition is a miserable one" (Rogers, 1898, pp. 152-153). As Farber (1968) writes, "Throughout

their history, state residential institutions for the mentally retarded have been at the mercy of political whims and patronage practices" (p. 183). Views such as Governor Butler's seem to attest to this.

But it was not just politicians whose attitude had changed. For example, Dr. George Knight, (1891) director of an institution in Connecticut, in responding to a paper entitled "Custodial Care of Adult Idiots" summarized his view of the role of the institution. He said:

I think we ought to talk about economy; I do every chance I get. The sooner you can make people understand that the most economical thing we can do is shut up every one of these children, especially the female, the more economical it is going to be for every State in the Union. If they inquire for statistics, I have a large number to give them. What was the cost to the State of New York of the Juke family, all descendants of a depraved and neglected imbecile? A million and a quarter dollars! This is not a matter of economy in spending but in saving money. (1891, p. 218)

And with these views, institutions continued to grow in size and number. As Tyor and Bell (1984) point out, the process became a cyclical one. They write: "Institutions expanded to relieve waiting list pressures but the expansions were rarely sufficient to meet the demands of the state's increasing population. Construction always lagged behind applications for admission" (p. 28). The end result was, that as each new building was completed, the cycle simply began again,

becoming larger and more complex with each iteration.

Interestingly, the founding fathers viewed this process with great skepticism. Wilbur, Seguin and Howe had divergent opinions about what services needed to be provided. Wilbur (1879) supported and promoted the institutional model, but was in favor of building specialized facilities rather than enlarging existing ones. He said in 1879, "I have had a prejudice against large asylums for any purpose. ... It was thought best to wait till an independent asylum could be established" (p. 98). Seguin (1866) was generally supportive of institutions, but established a private day school to explore alternatives to institutional care (Graney, 1979).

Howe deviated the most. Twenty years after opening the first public institution, he made the following remarks as the guest of honor at cornerstone ceremonies for a new institution for the blind. He said:

Our people have rather a passion for public institutions, and when their attention is attracted to any suffering class, they make no haste to organize one for its benefit.

But instead of first carefully inquiring whether an institution is absolutely necessary, that is, whether there is no more natural and effectual manner of relieving the class...they hastily build a great showy building and gather within its walls a crowd of persons of like condition or infirmity; and organize a community where everything goes by clock-work and steam. If there be a vicious principle in the organization, as of closely associating persons who ought to live apart, it is forgotten in

admiration of contrivances for making steam do what was once done by the good housewife, with her cook and maid.

But no steam power, no human power can long keep a vicious principle from cropping out. It has done so in many European institutions of charity; it will do so in many of ours. (Wolfensberger, 1975, p. 64)

White and Wolfensberger (1969) labeled the period from 1870 to 1890 as the period that "sheltered the deviant from society." Wolfensberger (1975) says, "The protective residential model emphasized benevolent sheltered, but it bore the seeds of three dangerous trends: (1) isolation, (2) enlargement, and (3) economization" (p. 29).

Two examples of developing trends were the use of resident labor and the establishment of the colony system. Residents worked at numerous tasks in the institutions, often for long hours, at little or no pay. Dr. J. Q. A. Stewart (1882) reported that he needed extensive renovations, including the digging of a basement, for his facility. The appropriation from the State was not sufficient to do the work, but he found an alternative. He reported, "All the work of moving the great body of earth heretofore spoken of was done by the boys during vacation. ... It is estimated that the work done by the boys, if paid for at usual prices, would have cost the State twelve hundred dollars" (p. 270).

Johnson (1897) reported on a work practice that

continued well into the twentieth century. He said, "There is no occupation so suitable for the middle grade imbecile as the care of the low grade idiot" (p. 22).

Osborne (1891) reported that in California residents were paid between twenty-five cents and two dollars a month for similar work. Speaking about the work of the institution he said, "To every extent possible the routine work will be performed by its corps of beneficiaries who have been trained to fill these positions as quasi-officers, trainers and artisans" (p. 179). These residents were given uniforms, treated as sub-officers of the home and allowed to spend their earnings as they chose.

Osborne's (1891) motives were not solely benevolent, however. In the same report he states other reasons for resident labor. He said:

It is solid business, and means to us an actual saving of thirty per cent on our annual pay-roll. Our books show that the fiscal year just closing will note a great reduction in our per capita cost for maintenance, notwithstanding our increased numbers and some extraordinary expenses included in the count. To those who may have underestimated the value of the children's work, the figures will be simply surprising. (pp. 179-180)

Many institutional directors at the meeting responded to Osborne's paper, all regarding resident's problems in properly handling money. The administrator of the Pennsylvania institution commented that he wanted to be "slow to cultivate that famous root, the love of

which is all evil." A second worried that if the practice of replacing staff with residents was carried too far "our boards may wake up some morning and begin abolishing the superintendents!" (Osborne, 1891, pp. 181-182).

Scheerenberger (1983) notes that although many of the accounts of resident labor are abusive by today's standards, labor was viewed much differently in the late 1800s. All family members were expected to contribute to the well-being of that family. Most administrators also believed that a "busy child is a happy child."

By the last decade of the eighteenth century schools for the mentally retarded had evolved into large institutions, most administered on the colony plan. Osborne (1891) described this system:

Ample acreage (not less than one acre per patient) will be provided for the proper seclusion of defectives from the stare of the idle and curious, and for the establishment of those "villages of the simple made up of the warped, twisted, and incorrible, happily contributing to their own and the support of those more lowly,--cities of refuge, havens of rest"--that the prophetic pen of Dr. Kerlin, so long ago graphically foretold and aptly described. Such a colony, of say fifteen hundred souls, will be cared for with less burden to the State, greater ease to the management, and more good to the patient than can now be secured through the agency of three separate institutions of five hundred capacity each. Opponents to our work make the most of a good argument, when they urge that defectives generally should not be singled out for extravagant care, nor be the recipient of attention in excess of the average cost for supporting children of intelligence under the public system; that the tax-payers should not be burdened by any



extras on account of those who have never added and may never contribute to society wealth or welfare, but, on the other hand, may at any time be destroyers of its peace. Under judicious management the per capita cost can always be reduced as the institution increases in numbers and becomes more and more generously equipped. The colony system will supply all conditions of demand, reduce per capita costs, enable the beneficiaries to contribute to a maximum degree to the institution's general support by the value of their assistance, and supplies the best answer to the question, "What shall be done with custodials, and those beyond the school age?" and seems to best satisfy our utilitarian age. (pp. 178-179)

This lengthy passage encapsulates and summarizes the changes that had taken place in institutions in the United States:

1. They had been moved to rural areas, to "provide proper seclusion" of the defectives.

2. Residents now worked to contribute to their own care and "the support of the more lowly."

3. Large numbers of mentally retarded people (as many as 1500) could be congregated for the "good" of the "patient" and to lessen the "burden" for tax-payers.

4. The mentally retarded had become those who "never added to society welfare" and "may at any time become destroyers of its peace."

As the century closed, institutions expanded, their administrators placed increased emphasis on the protection of society and the prevention of mental retardation by segregation and sterilization. The concepts of cost efficiency and effectiveness also became

part of the administrator's concern. Questions related to the annual cost of facilities were to become a central theme in testimony before state legislatures and in annual reports of facility operations.

### The Twentieth Century

Institutional growth would continue for almost seventy years into the twentieth century. The United States census counted 2429 residents in institutions in 1880, 4216 in 1890 and 9334 in 1900. As Figure 1 depicts, steady increases were reported from 1880 until 1967 when the institutional population reached a peak of 194,650 (Wieck & Bruininks, 1980, pp. 3-4).

The number of facilities grew to meet the increased number of residents. Shuttleworth (1877) visited all nine American institutions in the summer of 1876. By 1888 there were fifteen publicly supported facilities in fourteen states (Salisbury, 1891, p. 225). Kanner (1964) notes that in 1898 twenty-four public institutions were maintained by nineteen states and the City of New York (p. 66). Barr (1904) lists thirty facilities in existence soon after the turn of the century (p. 77).

As institutional populations expanded, the general image of mentally retarded persons also changed negatively. Beginning in the late 1800s and continuing for the first quarter of the 1900s, mentally retarded

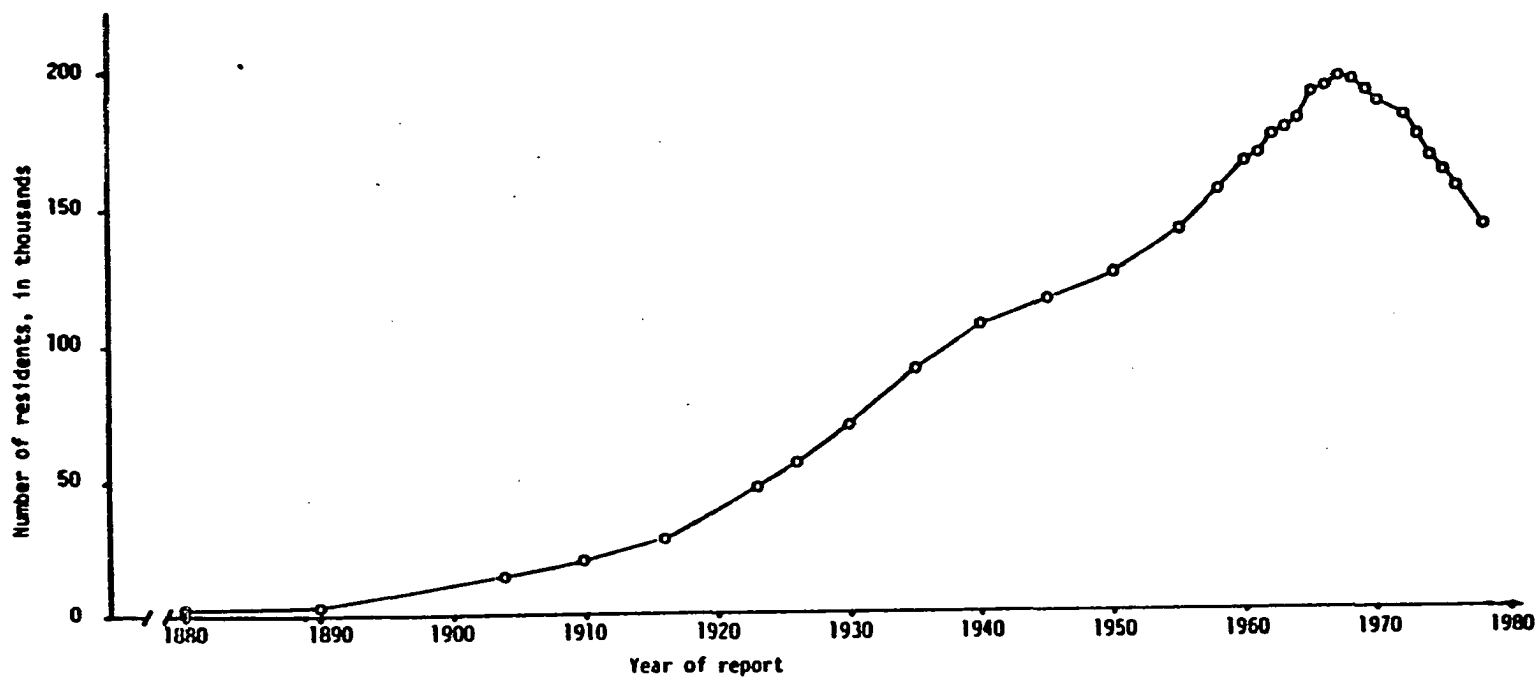


Figure 1. Total Populations of Mentally Retarded People in Public Institutions for the Period 1880 to 1980.

people were considered a menace to society.

This view was fostered by such noteworthies in the field as Dr. Isaac N. Kerlin, administrator of the Pennsylvania Training School for nearly thirty years. In many presentations to the National Conference of Charities and Correction (NCCC) and the American Association on Mental Deficiencies (AAMD) he made statements regarding public policy toward the retarded. For example, in 1884 Kerlin said, "But the State, adopting as its policy the protection in institutions of the defective classes, acquires a right of inquest into the causes generating this tremendous burden to the thrifty tax-payer, who must be protected from the rapacious social ills which deplete his own strength" (p. 262). This statement was the conclusion to a report of the Standing Committee on Provisions for Idiotic and Feeble-minded Children of the NCCC. The majority of the report was devoted to the dangers of having only 2,429 of a reported 76,985 feeble-minded people institutionalized nationally (p. 247).

Kerlin based most of his arguments about the menace of the mentally retarded on "evidence" provided by Dugdale's (1910) study The Jukes. This was a genealogical study of six generations of a family that had a large number of legitimate and illegitimate children. He studied 509 relatives directly related to

the family by blood and 169 by marriage or cohabitation. Dugdale found a preponderance of harlotry, illegitimate children, pauperism, deformed children, syphilis and a higher crime rate among the 509 blood relatives compared to the 169 descendants resulting from marriage. Dugdale concluded that his findings were due to environment. He wrote, "The tendency of heredity is to produce an environment which perpetuates that heredity: thus the licentious parent makes an example which greatly aids in fixing habits of debauchery in the child. The correction is change of environment" (p. 65). But then he added, "Environment tends to produce habits which may become hereditary, especially so in pauperism and licentiousness, if it should be sufficiently constant to produce modification of cerebral tissue" (pp. 65-66).

His conclusions were ignored by most authorities. Many leaders in the field of mental retardation, including Kerlin, thought that the Juke women were retarded which therefore caused the high prevalence of other social problems. Kerlin (1884) asked in his NCCC speech, "How many of your criminals, inebriates and prostitutes are congenital idiots?" If this class of idiots could be permanently sequestered this would prevent "their assuming social relations under marriage, or becoming sowers of moral and physical disease under the garb of professional tramps or degraded prostitutes"

(pp. 256-258).

It should be noted that similar views of mental retardation facilities were held outside the circles of administrators and superintendents. In 1888, Oscar McCulloch presented a paper to the Conference on Charities and Corrections entitled, "The Tribe of Ishmael: A Study of Social Degradation." In his study, as with Dugdale's, there appeared the same histories of pauperism, crime and prostitution. McCulloch warned of the costs to the public good if hereditary defectives went unregulated and called for comprehensive institutionalization of such persons (pp. 154-159).

It was this type of attitude and view of the mentally retarded that tightly linked them with numerous social ills. At the turn of the twentieth century institution administrators used this linkage to promote their facilities as solutions to crime, pauperism, disease, prostitution, alcoholism and vagrancy. As Tyor and Bell (1984) point out, "This new, additional function would be the sole, or at least the most important, mission of the institution" (p. 69).

At the turn of the century many administrators saw their role as one of preserving the fiber of the nation. The encroachment of imbecility, crime and other problems had to be slowed. Dr. Walter E. Fernald was the first resident superintendent of the Massachusetts School for

the Feeble-Minded and spent most of his life developing facilities and programs for the mentally retarded. Fernald (1915) summarized the factors that changed the view of the mentally retarded during this period. The four factors he presented were:

1. The widespread use of mental tests has greatly simplified the preliminary recognition of ordinary cases of mental defect and done much to popularize the knowledge of the extent and importance of feeble-mindedness.

2. The intensive studies of the family histories of numbers of the feeble-minded by Goddard, Davenport, and Tredgold have demonstrated what had hitherto only been suspected, that the great majority of these persons are feeble-minded because they come from family stocks which transmit feeble-mindedness from generation to generation in accordance with the laws of heredity. Many of the members of these families are not defective, themselves, but these normal members of tainted families are liable to have a certain number of defectives among their own descendants. The number of persons who are feeble-minded as a result of injury, disease, or other environmental conditions without hereditary predisposition is much smaller than had been suspected, and these accidental cases do not transmit their defect to their progeny.

3. The cumulative evidence furnished by surveys, community studies, and intensive group inquiries have now definitely proved that feeble-mindedness is an important factor as a cause of juvenile vice and delinquency, adult crime, sex immorality, the spread of venereal disease, prostitution, illegitimacy, vagrancy, pauperism, and other forms of social evil and social disease.

4. Our estimates of the extent and the prevalence of feeble-mindedness have been greatly increased by the application of mental tests, the public school classes for defectives, and interpretation of the above-mentioned antisocial expressions of feeble-mindedness, and the intensive community studies. Goddard believes that at least 2 per cent of school children in the first grades are

mentally defective. It is conservative to say that there are four feeble-minded persons to each thousand of the general population. (pp. 289-290)

Heredity became the focal point of the retardation movement. Dr. Martin Barr (1904), who was the chief physician of the Pennsylvania Training School for Feeble-Minded Children, stressed this fact in his text Mental Defectives: Their History, Treatment and Training. He wrote, "heredity is herein proven law, as inexorable in its descending as it is beneficent in the ascending scale; heredity--whether it be direct from parent to child, collateral as from other relatives, or reversional reappearing ever and anon through generations--which none may escape" (p. 123). Barr, and others, were undoubtedly influenced by the American eugenics movement.

Eugenics is a term coined by Sir Francis Galton in 1883 and refers to a study of the improvement of the quality of the human race. Haller (1963) defines it as, "the effort to improve the inborn characteristics of man by the study of human heredity and the application of those studies to human propagation" (p. 3). Smith (1985) observes that an early aim of the eugenics movement was elimination from the population of unwanted hereditary disorders by selective marriage. "Quickly, however," he writes, "the movement spread to encompass not only the promotion of compulsory sterilization of people with undesirable traits but also the restricted immigration of



unwanted races and nationalities--groups that by eugenic definition possessed inferior hereditary material" (pp. 2-3).

In 1907, Charles Davenport became Secretary of the Committee on Eugenics of the American Breeders Association. In 1911 this group recommended life-long sexual segregation of the mentally retarded, along with sterilization, so that they could not reproduce.

Many facility administrators were receptive to the goals of Davenport's movement because it reinforced their own convictions regarding the necessity of preventing propagation of defectives. While advocating adoption of custodial provisions, superintendents knew that many mentally retarded people would never be institutionalized and therefore were beyond the reach of segregation and eugenic control. Dr. A. W. Wilmarth (1895) warned his professional colleagues that the public would be slow to understand this principle, even though administrators knew differently. He said:

The best of all methods of prevention, the prevention of the marriage of the unfit and their increase by propagation appears as far off as ever. The public are singularly slow to realize the importance of reform in this direction or to adopt any remedy. The marriage of two imbeciles, epileptics or other neurotics may excite indignation in the minds of the few who realize the enormity of this crime against the future. It may excite a mild amusement even in the thoughtless, (and they are very many), and be viewed by the great majority of the public with a supreme indifference, little realizing that in a very few years the two

defectives may become three, five, perhaps more. Year after year we have asked the public attention to this evil, have cited case after case until we ourselves are heartsick from the misery and wrong we recite, but public opinion, hardened by constant contact with this condition, becomes educated with the most discouraging slowness, and we have but to continue the thankless task of arousing the public mind by continued recital of precept and recital of examples. (p. 518)

Action was taken by several states to limit marriage rights. Connecticut acted first (1896), followed by Kansas (1903), New Jersey and Ohio (1904), Michigan and Indiana (1905). The National Conference of Charities and Correction during the first decade of the century annually called for limitations on defective procreation (Tyor & Bell, 1984, p. 96).

By 1914, Smith, a special education teacher, reported that thirty states had enacted restrictive marriage laws. Most of these simply make marriages of idiots and the insane voidable on the grounds that such people were incapable of making a contract. "However," Smith (1914) noted, "in a number of cases the prohibition is apparently made primarily on eugenical grounds--for the purpose of cutting off bad germplasm" (p. 365). Smith concluded her argument with a statement that summarized the concepts of this era. She said:

No one with any regard for social improvement desires to see the state of marriage unnecessarily fenced around with legal impediments, or wishes to infringe upon the personal rights of any individual. He simply asks that the matter be scientifically regarded. Society has been awakened to the fact

that it is responsible for its own sins. We are rapidly coming to the realization that it is not only our right, but our duty to protect the future from the evil of the past and the present. (p. 370)

The rights of individuals did come into question during this period. Superintendents were conscious of potential conflicts regarding individual rights. Martin Barr (1902) said, "The spirit of our Constitution protects every man in his inalienable right of the pursuit of happiness, it is true, but only when that pursuit does not conflict with the rights of his neighbor" (p. 163). Yet to Barr the conflict of rights was illusory. In a statement reminiscent of a Roman legal decision centuries before he said, "it must be remembered that we are dealing not with men, but with an arrested development which constitutes a perpetual childhood, as incapable of the responsibilities of parenthood as it is of intelligent suffrage" (p. 163).

Attempts to write marriage laws were seen as ineffective. As Murdock (1913) said, "Restrictive marriage laws are unavailing because the unfit reproduce their kind regardless" (p. 37). "Alas, sex," Wolfensberger (1975) would add, "even less than alcohol later on, was not easily outlawed" (p. 40).

Eventually the constitutionality of sterilization was tested. By 1926, twenty-three states had enacted laws approving involuntary sterilization of the mentally

defective; but those in Indiana, Nevada, New Jersey and New York had been ruled unconstitutional. Laws in Michigan and Virginia were tested in the courts but were declared constitutional.

In 1927 the case of Carrie Buck came before the Supreme Court of the United States. Carrie Buck was an eighteen-year-old mentally retarded woman who had a child out of wedlock that had been labeled mentally retarded. Carrie's mother was also considered to be mentally retarded. The superintendent of the state institution in Virginia, where Miss Buck was a resident, petitioned a local court to have her sterilized. The court approved the request, however, the decision was appealed by Miss Buck's guardian. Justice Holmes of the United States Supreme Court upheld the state's authority to mandate sterilization for the general welfare of society. Hughes (1940) records a portion of the Court's decision. It was held that:

three generations of imbeciles are enough. It is better for all the world, if instead of waiting to execute degenerate offspring for a crime, or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind. (p. 23)

Smith (1985) remarks, "Thus, the precedent was set giving state governments the right to intervene in the reproductive practices of citizens who were deemed defective in some way" (p. 149). He also notes that

later research indicated that neither Carrie Buck nor her daughter were mentally retarded and that there were not "three generations of imbeciles" as Justice Holmes thought (p. 152).

Authorities realized that in the early 1900s only one in ten mentally retarded persons was institutionalized, meaning that there was a continued need to prevent the defective from reproducing while not in custodial care. To some, sterilization offered a way to prevent procreation without severe physiological and psychological side effects.

Gallichan (1929), in a book entitled The Sterilization of the Unfit bemoans the fact that society excels in the scientific breeding of horses, cows and dogs, but that the production of superior men and women is left to chance. He said, "The highly prolific Unfit of the Western world are increasing in tens of thousands, while we are concerned with preserving a pure strain of Sealyham terriers" (p. 12). Procreation of the feeble-minded was a geometric process according to Gallichan and total decay of society was inevitable unless something was done. His answer: "If sterilization became the legal practice in the United Kingdom, feeble-mindedness would become rare, and would probably approach extinction in the future" (p. 18).

Supporters of asexualization, such as Samuel Risley

(1905), saw it as a means of restoring the natural selection process which they believed was failing to occur because defectives were no longer allowed to die off. To this group, the primary cause of the large number of degenerates was heredity. The surest way to eliminate defective heredity was to prevent reproduction.

Not all agreed with this approach. Legislation in Michigan (1897) and Pennsylvania (1905) was vetoed. Pennsylvania's governor, Samuel Pennypacker, did not believe that available scientific evidence supported such drastic acts, which seemed beyond state authority and were performed without the consent of the imbecile children or their guardians. He concluded, "To permit such an operation would be to inflict cruelty upon a helpless class in the community which the state has undertaken to protect" (Laughlin, 1922, p. 35). Scheerenberger (1983) adds, "Neither the professional community as a whole, political representatives, nor the public in general were enthusiastic about sterilization" (p. 155).

Regardless, between 1907 and 1958, 30 states reported sterilizing approximately 31,000 mentally retarded persons (Davies, 1959, p. 54). Butler (1945) notes that 21 percent of all admissions to California institutions were for the purpose of sterilization. Two years later Butler and Gamble (1947) reported that an

institution in California had managed to sterilize 95 percent of the fertile patients that they discharged (p. 559). The institution where Carrie Buck lived sterilized more than 4,000 people between 1927 and 1972, when they abandoned the practice.

In 1949, Gamble noted that the problem with expanding the practice was that the general public did not understand the procedure. If more education was available the public would "consider the protection of a mentally ill or defective person from parenthood without a vicarious but unjustified shudder over the supposed loss of sexual characteristic" (pp. 540-541).

Tyor and Bell (1984) state that the concern for the menace of the feeble-minded reached a peak between 1912 and 1917. Committees were established to alert the public. In 1910 friends and families of children waiting for placement in the Vineland institution in New Jersey organized into a Committee on Provision for the Feeble-Minded. Through a letter writing campaign, pressure was put on the legislature to pass a series of bills to create additional institutions for the mentally retarded. In 1914 a National Committee on Provision for the Feeble-Minded was established in Philadelphia (Johnstone, 1916; Byers, 1916). These groups, and others like them, worked toward the expansion of facilities for the feeble-minded in order to remove them from society.

To summarize, many professionals in the early 1900s believed that heredity was the prime factor associated with mental retardation. Retardation was considered to be the source of many social ills during this period; but attempts to control marriage were impractical and sterilization, at least on a wide scale, was not generally accepted by the public. The remaining alternative was segregation through institutionalization.

Murdock (1913) summarized this view. He wrote:

We must get away from the idea, and get the public away from the idea, that our institutions for the feeble-minded are institutions simply for the training of feeble-minded children. The care of the feeble-minded is, as the care of the insane, a problem for the state, not the city or county. The good to be accomplished by the segregation of an able-bodied feeble-minded woman is too remote to appeal to the shortsighted local guardian of the poor who is too interested in keeping down the tax rate in his district during his term of office and is too accessible to the family and friends of one who should be segregated. (pp. 34-35)

The eugenics period prevailed for a relatively short period of time, but the distortions from this period carried over and became the lasting foundations upon which institutional programs were built. Long after the hereditary studies and the works of people such as Dugdale, McCullough and Davenport were criticized for haphazard research techniques, their effects still existed.

Selznick (1957) observed this phenomena in defining how organizations become social institutions. He found



that values become embodied and infused into the organizational structure and, as a result change is difficult. He says, "As in the case of individuals, the emergence of organizational character reflects the irreversible element in experiment and choice" (p. 40). The attitudes fostered in this period become an irreversible element and the segregated institution, asylum and hospital for the retarded would remain part of the system for decades to come.

The era following World War I saw expansion and change in the roles of these institutions. New assumptions and facts about the number of mentally retarded people in the general population contributed to the change. Doll (1929) chronicled this period. In 1920 a report by the Surgeon General of the Army found that the prevalence of feeble-minded persons was twelve per thousand in the general population. Other studies found between twenty to twenty-five per one thousand. To some, these numbers meant that mental retardation was increasing. Doll's conclusion was that some type of community supervision was needed because institutions could no longer hold all the mentally retarded people. In addition, he noted that all mentally retarded individuals did not need incarceration; they already lived within society performing useful, menial tasks (pp. 161-174).

Institutions began to expand their role into the community. This first occurred through releasing those residents who were determined to be "self-supporting." Dr. W. A. Polglase (1900), superintendent of the Michigan School for the Feeble-minded, claimed, "Twenty-five percent of our inmates would be self-supporting if work were put into their hands to do" (p. 425). In 1912, Fernald caused a great deal of debate by presenting the concept of parole for institution inmates. Many professionals disagreed with Fernald, stating that the mentally retarded could not simply be released. His answer was that only those trained should be released and that there was purpose to the parole system. He said,

It is a question as to whether we should allow their parents to take them out for we want to keep a legal hold on them and given them a bit of supervision. We either have the choice of doing that or losing control. (p. 110)

Parole also served another purpose according to Fernald (1912). Those released served as "object lessons" and helped the community remember the problems of mental retardation. This garnered support for other policies he ardently supported--more institutions, registration of the feeble-minded, court commitment when parents refused, segregation, compulsory surgical sterilization and public education to insure rational protection and control of feeble-minded persons (pp. 94-98).

Coupled with the parole system was the colony system. At first, most colonies were farms that gave work to 50 to 200 male residents. In the first three decades of the twentieth century, Charles Bernstein (1917) revised the colony concept to include houses in the city. He believed that institutions could not provide the training nor the environment necessary to develop non-deviant behaviors. Kuhlman (1940) noted that the innovative aspect of the colony system was that the "inmates" were employed in the neighborhood for wages, some of which were credited to their account (p. 15). The person worked and returned to the colony as a place to live.

Reporting on family home placements Bernstein (1917) said, "the only fair treatment ... is to give them one or more favorable trials in a normal, well-selected family. ...For does not every normal child develop through experience and right habit-forming opportunities?" (p. 160).

A number of Bernstein's (1917) programs were for women. In 1914 he placed an advertisement in the Rome, New York newspaper. It read in part, "A working girls' home has been established at 209 West Thomas Street, where girls are available for domestic work, sewing, etc." (p. 156). This house allowed women to leave the institution and become self-sustaining, which 63 percent

did. A later report from the Rome State School showed that, of 636 parolees, the majority had successfully become laborers and members of the armed forces. (Foley, 1929, pp. 180-204).

Institutions continued to become involved in the community by establishing outpatient clinics. Clinics offered advice and counsel to families and professionals in local settings. One such clinic in Pennsylvania was critical to the later development of special school programs and expanded community services. Tyor and Bell (1984) note that this success was due in part to a change in attitude by Dr. Walter Fernald. For decades he had been an advocate of segregation and other means of social control for the mentally retarded, but in 1923 he adjusted his position. He urged fellow professionals to assist clients in adjusting to home and community living and in finding employment (Fernald, 1923, pp. 216-219).

The 1930s saw another shift in attitudes regarding the care and treatment of the mentally retarded. The professional literature began to reflect the concepts of community living and training in public schools (Brown, 1931; Little & Johnson, 1932; Berry, 1930). The idea that mentally retarded persons were receptive to positive moral influences was a perspective sharply different from the innately vicious person view held during the late nineteenth century.

Scheerenberger (1983) lists eight reasons for changes in attitudes about residential services. They are:

1. Resources would not allow for the institutionalization of all mentally retarded people.
2. Families often did not want their children placed in institutions. They saw no advantage to their children or society in segregation.
3. Most institutions were overcrowded and understaffed and did not provide the environment and services needed by residents.
4. Schools began to be more favorably inclined toward serving the mentally retarded child.
5. Mentally retarded people were demonstrating their ability to meet the demands of society.
6. The doctrine of heredity and degradation was successfully challenged in the courts and the community.
7. Attitudes toward other institutions (prisons and orphanages) were also in the process of change.
8. Mentally retarded men had successfully served in the armed forces during World War I.

These influences did not give all mentally retarded person free and equal access to the community nor did they slow institutional expansion, as can be seen in Figure 1. A 1930 White House Conference on Child Health and Protection proposed a multi-stage attack on the

growing problem of mental retardation. Stage one was identification and registration; stage two was early diagnosis; stage three was the training of some and segregation of others; stage four called for social control of the retarded in the community (including sterilization); and stage five called for research (Scheerenberger, 1983, p. 199). The report of the conference also included a Bill of Rights for the Handicapped Child. The child had a right:

1. To as vigorous a body as human skill can give him.
2. To an education so adapted to his handicap that he can be economically independent and have the chance for the fullest life of which he is capable.
3. To be brought up and educated by those who understand the nature of the burden he has to bear and to consider it a privilege to help him beat it.
4. To grow up in a world which does not set him apart, which looks at him, not with scorn or pity or ridicule--but which welcomes him, exactly as it welcomes every child, which offers him identical privileges and identical responsibilities.
5. To a life on which his handicap casts no shadow, but which is full day by day with those things which make it worthwhile, with comradeship, love, work, play, laughter, and tears--a life in which these things bring continually increasing growth, richness, release of energies, joy in achievement. (Johnstone, 1931, p. 340)

Sloan (1963) states that the 1930s was a time of general pessimism, characterized by building larger institutions and cramming them to capacity. He says the mentally retarded were forgotten while professionals debated the welfare state and if people existed for the

State or the State for the people (p. 12).

Wolfensberger (1975) also notes that community services were slow to develop in the 1930s and 1940s, partially because of a lack of funds, concentration on larger social problems and a growing number of impoverished and destitute citizens. As a result existing institutions became more rigid. Specifically, community services did not develop because (a) the populace had been indoctrinated for too long about the menace of mental retardation, (b) professional interest in the field had diminished, (c) the Depression all but stopped funding for community services, and (d) World War II diverted public attention from the concerns of mentally retarded people (pp. 55-56).

Another White House Conference in 1940 noted the failures of programming for mentally retarded people. The report stated that education and employment in the community were frequently the best treatment and called for comprehensive programs of care. Each state was urged to develop a state-wide plan. The report concludes:

Supervision of the mentally deficient who may with some help carry on normal activities in the community should be a major element in the State-wide program, but, as yet, it has not been developed to a very extensive degree. Many such persons need never go to an institution; others may adjust to life in the community under supervision after institutional education and training. There is good reason to believe that the number who may benefit from such supervised life far exceeds the number that requires permanent segregation. (United States

Children's Bureau, p. 275)

With this foundation, the federal government began to show more interest in the mentally retarded. Scheerenberger (1983) highlighted a few of these activities:

1943: the Industrial Rehabilitation Act of 1920 was amended to create the Office of Vocational Rehabilitation, intended to serve both mentally and physically disabled persons.

1946: the National Mental Health Act established the National Institute of Mental Health, which devoted funds to both training and research in mental retardation.

1950: the National Institute of Neurological and Communicative Disorders and Strokes was created, which sponsored a major perinatal research project.

1954: the Cooperative Research and Education Act was passed, which for several years provided research funds for mental retardation.

1956: the National Institute of Mental Health earmarked \$250,000 for mental retardation research.

1957: the Department of Health, Education, and Welfare made federal funds available to promote and support specialized diagnostic clinics for mentally retarded persons.

1957: the Social Security Act, 1935 was amended to



include a disability clause to provide retirement income to survivors in case of death or disability, which also authorized payments to "adult disabled children."

1958: the first categorical piece of legislation specifically devoted to mental retardation was passed: P.L. 85-926 authorized federal funds to universities for training of mental retardation specialists. (p. 228)

Professionals also started to voice concerns about the impact of institutional life upon the residents. Otness (1950) described conditions at the Rainier State School in Washington. He said, "The residence halls have been crowded beyond the point of decency and humanitarianism for children" (p. 20). Overcrowding by 30 to 40 percent came to be the rule rather than the exception nationally. In 1956, there were 100 institutions in the United States with inpatient populations ranging from 29 to 5,375. Almost 25 percent of the hospitals had a population over 2,300 patients and 30 percent had waiting lists exceeding 300 (Fish and Foster, 1956, pp. 319-326).

By 1950 many administrators began to advocate admitting only children who could not be cared for properly at home (Storrs, 1950, p. 181). Interestingly federal census figures indicate that institution populations continued to rise dramatically. At year's end in 1940 there were 101,583 people in institutions,

129,399 in 1950, 163,730 in 1960 and 186,743 in 1970. National admission rates for this period are also interesting. In 1940, 10,714 persons were admitted; in 1950, 12,233; in 1960, 14,701; and in 1970, 14,985. The peak admission year was 1967, with 15,714. (United States Bureau of the Census, 1975, p. 85). Ellis notes that three quarters of the institutions in the United States were constructed or expanded after 1950 to accommodate the demands for additional beds (Scheerenberger, 1983, p. 240).

In the 1950s individuals admitted to facilities tended to be younger and more severely handicapped. In studying this phenomenon Goldstein (1959) concluded, "Since the young, custodial type of admittees are rarely amenable to training and extra-mural placement, it might be expected that they are therefore destined for long-term residency" (p. 604).

An increasingly dependent population cast the institution into a role where maintenance of residents became the overwhelming concern. Scheerenberger (1983) says that, "Treatment of the difficult-to-manage resident or those who could not attend often relied on medication, camisoles, straitjackets, lock-ups, physical punishment, or tying to the bed" (p. 242).

It should be added that the images of snake-pits and wholesale abuse of the mentally retarded did not exist in

all institutions. The Wayne County Training School in Michigan, the Vineland Training School in New Jersey and the Pacific State School in California were developing innovative programs for severely handicapped persons and children with severe behavior problems (Hegge, 1952; Deacon, 1952; Freeman, Ott & Dunsmore, 1956). Also new combinations of treatments were being tried. Tyor and Bell (1984) note that milieu therapy, psychotherapy and psychopharmacology were all used with the mentally retarded beginning at mid-century (pp. 142-144).

Reform was needed and in the 1950s it was beginning. After World War II parent groups began to be established in many regions around the nation. In September, 1950, the National Association of Parents and Friends of Mentally Retarded Children, later known as the National Association for Retarded Children, was organized. This group grew to a membership of over 218,000 in 1,700 state and local units by 1970. The President's Committee on Mental Retardation (1977) said the organization "served as a social catalyst at local, state, and national levels to galvanize political change, modify public attitudes, and stimulate professional attention in a manner virtually without parallel among voluntary service organizations" (p. 39). The coalition became a powerful pressure group, demanding that training and rehabilitation replace custodial care in institutions.

Some institution administrators also sought change. For example, Ernest Rozelle (1954) of Connecticut wrote an extensive article detailing how the institution should be sub-divided, with smaller (24-50 person) housing units, community areas and schools. He said, "One is appalled, as one observes and studies many institutional plants throughout the country, to note their manifest inadequacies in meeting even minimum essentials of a modern program for child care and training" (p. 597).

Rozelle (1981) believed that the role of the institution was to train children and return them to their communities. In exchange, he asked society to supply "adequate plants to house adequate programs to meet this responsibility" (p. 598). Interestingly, society, and even the advocates within it, did not have an equivalent view. Two years after Rozelle's article, Joseph Weingold (1956), executive director of the Association for the Help of Retarded Children in New York, was asking the state senate to construct no new institution for more than 1,500 people. Reform was to be a slow process.

The period from World War II through the 1950s was a time of contrast in residential care and treatment of people who were mentally retarded. The biases related to heredity and degradation began to dissolve, but increasing urbanization left little space for mentally

retarded persons. Although public school programs were developed in the community, the demand for institutions continued. As institutions grew, they began to have problems in meeting the multiplicity of needs presented by a wide range of people. Consequently, they often failed to provide even essential care and treatment. While some critics called for institutional reform, other alternatives were rarely available. This period set the stage for the changes in succeeding decades.

The years 1960 to 1980 brought major changes to the systems for care and treatment of mentally retarded people. Scheerenberger (1976) states that several trends were evident that shaped this transformation. They were (a) expanded recognition of human and civil rights, (b) changes in concepts of programming, (c) development of standards of care and treatment, and (d) increased funding of human services.

Sellin (1979) states that the 1960s brought a broad based attack on the problems of mental retardation. Federal laws expanded efforts in employment, education, health and social services. During the decade much emphasis was placed on planning and action with great strides being made in such areas as interagency efforts, medicine and behavioral psychology.

Bruininks et al (1981) claim that these trends and changes were as extensive as any in the history of the

care and treatment of mentally retarded people. They state that they "can only be attributed to a philosophic and social revolution as radical and as sweeping as was the initial movement to build institutions for mentally retarded people in the late 19th and early 20th centuries" (p. xi).

The catalyst for much of this change was the appointment of the President's Panel on Mental Retardation by President John F. Kennedy in 1961. In making the appointments, Kennedy said:

The manner in which our Nation cares for its citizens and conserves its manpower resources is more than an index to its concern for the less fortunate. It is a key to its future. Both wisdom and humanity dictate a deep interest in the physically handicapped, the mentally ill, and the mentally retarded. Yet, although we have made considerable progress in the treatment of physical handicaps, although we have attacked on a broad front the problems of mental illness, although we have made great strides in the battle against disease, we as a nation have for too long postponed an intensive search for solutions to the problems of the mentally retarded. That failure should be corrected. (President's Panel on Mental Retardation, 1962, p. 196)

The charge to the panel was to develop a comprehensive and coordinated attack on the problem of mental retardation.

The 1962 report of the Committee emphasizes prevention and research. It also stated that services to mentally retarded people should be comprehensive and provided through community-based programs.

Responsibility for these services would belong to the states and local communities, with limited federal financial assistance.

The Committee's report is a compendium of service needs including education, residential, religious and vocational. Scheerenberger (1983) observed that while the panel's ideals were important, they were not new. He said, "Close examination reveals that most of the ideas and services suggested were identical to those proposed by Walter Fernald, Charles Bernstein and others decades earlier" (p. 248).

The importance was that other factors and attitudes in the nation created receptivity to the calls for change. According to a United States Department of Education publication, Summary of Existing Legislation Relating to the Handicapped (1980), Congress passed 116 acts or amendments related to the mentally retarded between 1960 and 1980. These were in areas related to education, employment, health, housing, nutrition, rights, social services, transportation and vocational rehabilitation.

Braddock (1985a) found that the federal government funded 82 programs related to mentally retarded people between 1935 and 1984. Of the cumulative total of \$62 billion budgeted, 53 percent of these funds have been deployed since 1979. The vast majority of funds have

been spent since Fiscal Year 1974. He writes, "The number of relevant Federal programs identified in this study is convincing testimony to the effectiveness of the professional and consumer organizations in the field. Only a generation ago, there was virtually no Federal funding for MR/DD programs" (p. 19). (It should be noted that the initials MR/DD are an abbreviation for the words mental retardation and developmental disability. The second is a term which broadens the definition of the service population to include other disability groups.)

Legislation was not the only action that fueled changes during this period. Reform drives and protests of all types occurred in the mid and late 1960s. Tyor and Bell (1984) state, "many mental retardation workers acquired a new sense of purpose and dedication which reflected much of the furor and commitment expressed in antiwar demonstrations, civil rights protests and the war on poverty" (p. 146).

Richard Kock (1969), president of the American Association on Mental Deficiency, attempted to link that organization to the efforts of others. He told delegates that 75 percent of the mentally retarded were connected in one way or another to poverty. He went on to relate the problems faced by the mentally retarded to issues such as open housing, racial unrest, Indian turmoil and the Viet Nam war. He concluded with another battle cry



of the era: "The medical model for provision of residential services is no longer tenable" (p. 4).

Interestingly, Kock and others saw the mentally retarded person as one who had been environmentally damaged and whose numbers could be reduced by the elimination of poverty and discrimination. The retarded were no longer viewed as a menace requiring segregation or sterilization--their problems were instead related to education and social welfare.

In addition to legislation and social reform, reexamination of the institutional concept was being urged by various client advocates. Blatt (1970) wrote a book entitled Exodus from Pandemonium: Human Abuse and a Reformation of Public Policy. In this work he detailed the abuses suffered by mentally retarded people in institutions. He wrote,

I know personally of few institutions for the mentally retarded in the United States that are completely free of dirt and filth, odors, naked patients groveling in their own feces, children in restraints and in locked cells, horribly crowded dormitories and understaffed and wrongly staffed facilities. (p. 12)

Similar work was done by Rivera (1970) and Biklen (1970), all with a central theme, for decentralized care and integration within the normal community.

The federal courts became involved in issues related to the mentally retarded people in the 1970s. In 1972, Federal District Judge Frank M. Johnson of Alabama

established a legal right to treatment and habilitation in the Wyatt v. Stickney decision. The court designated three conditions for adequate and effective treatment: a humane psychological and physiological environment, qualified staff in sufficient number and individualized treatment plans. Hoffman and Dunn (1975) state, "The teeth of the Wyatt decision are its quantitative requirements, which provide a definite measure of the hospital's performance" (p. 304). Confinement in an institution could only be justified if an institution met approved standards of care. As a result of this case many people were moved to community residences by order of the court.

A second area of judicial intervention involved due process. Schwindler (1974) states that the basic objective of the due process clause "is to safeguard the individual and his well-being--i.e., his life, his independence of action and his possessions." As applied to the mentally retarded the due process clause implies that each citizen, regardless of intelligence, has the right to live in the least restrictive environment and participate in the mainstream of society to the fullest degree possible (Scheerenberger, 1980a, p. 8 ).

Scheerenberger (1980a) notes that in deciding O'Connor v. Donaldson in 1975 the U.S. Supreme Court stated that, "mere public intolerance or animosity cannot

justify the deprivation of a person's physical liberty."

He concluded:

The substantive aspects of due process are of great import. They clearly declare that mentally retarded persons should enjoy the privileges and responsibilities of full citizenship and should have their needs met in an open community, except in extreme circumstances. No longer, for example, should mentally retarded children or adults be placed in a state residential facility because of family rejection or inability to cope with the problems of living, the absence of appropriate educational programs, the lack of employment opportunities, or fear of sexual involvement, or simply because they are physically different, slow or demonstrate peculiar mannerisms, and community alternatives must be created. (p. 85)

A third area in which the court system became involved related to involuntary servitude. As mentioned, public residential facilities often relied on resident labor for jobs ranging from grounds up-keep to direct care of younger or more disabled residents. In 1973, Souder v. Brennan brought a class action suit against the United States Department of Labor to compel it to enforce the Fair Labor Standards Act of 1966. The decision read,

The Secretary of Labor has the duty to implement reasonable enforcement effort of applying the minimum wage and overtime compensation provision of the Fair Labor standards Act to patient workers at non-federal institutions for the residential care of the mentally ill and/or mentally retarded. (Scheerenberger, 1980a, p. 91)

Although this ruling was later overturned, the precedent was established that residents were no longer to provide free labor.

Finally, note should be given to two cases in

Pennsylvania and Washington, D.C. Parc v. Commonwealth of Pennsylvania and Mills v. The Board of Education decided that no child could be denied public education because of mental, behavioral, physical or emotional handicaps. When linked with decisions regarding services to people in residential facilities, these rulings allowed education programs to be extended to institutions. Many of the provisions of these rulings were incorporated into the Federal Education for All Handicapped Children Act (P.L. 94-142) which mandated full educational opportunities for all handicapped students, ages 3 to 21.

Deinstitutionalization and institution reform became the themes of the 1970s. Deinstitutionalization is often defined vaguely. Bachrach (1976, p. 2) points out that the concept sometimes means simply moving patients out of state hospitals or schools. Others consider the term to be synonymous with community mental health and community based services. In its most basic sense, deinstitutionalization means removal of people from state hospitals and schools for the retarded as well as transfer from one type of institution or placement into another type (Ashbaugh & Bradley, 1979).

A second use of the word deinstitutionalization relates to the design of the care-giving system. Halpern et al. (1980) note that in this context the term refers

to the provision of noninstitutional treatment or the design of a care-giving system that stresses noninstitutional care. The use of the word in this context may indicate the complete avoidance of state hospital care by placing the individual in other types of living arrangements (i.e., nursing homes or community group homes). The purpose is to reduce induced institutional dependence.

Deinstitutionalization became a primary objective in the 1970s when President Richard Nixon set a national goal of reducing institution populations by 30 percent before the turn of the century (Scheerenberger, 1980b). Movement toward this goal is reflected in the fact that between 1970 and 1979 institution populations went from 189,956 to 148,734 or a decrease of 41,222 mentally retarded people (United States Bureau of the Census, 1984, p. 111).

In order to accomplish this goal not only did institutions have to make a concerted effort to increase the independence of their residents, but communities had to develop the many services essential to maintain mentally retarded people within society. This is the reason Bachrach (1981) states, "it is erroneous to look at deinstitutionalization unidimensionally as if it referred only to persons released from institutions. It is, in fact, a much broader event that effects even

persons who have never been hospitalized" (p. 54). Slowness to comply with legal mandates and the urgings of advocacy groups to relocate residents to smaller care settings resulted from the lack of community based systems as well as institution activities. In other words, institutions alone could not be held culpable for the fact that community placement did not always proceed as fast as some thought it should.

In the entire history of the care and treatment of mentally retarded people no period of time rivals the two decades beginning in 1960 for humanitarian change. Local, state and federal support developed for a wide range of programs. There was involvement by the executive, judicial and legislative branches of government, as well as many private organizations.

In the last five years of this period (1975-1980) there was a profusion of special handicap provisions attached to general purpose legislation, accompanied by an expansion funds expended for such programs. Braddock (1985b) states,

The foundation established during the 1970-'75 period in special education (P.L. 94-142), income maintenance (Supplemental Security Income) and health care (ICF/MR) supported total Federal developmental disabilities expenditures of \$2.7 billion in FY 1980. This was an unadjusted increase of over 200 percent over the 1975 funding level. (p. 14)

Histories of this nature frequently do not include

recent events because their impact cannot be fully appreciated. Yet, brief mention of a few factors is warranted. Braddock, Hemp and Howes (1985) have found that between 1977 and 1984 the number of persons residing in state mental retardation centers dropped by 27 percent, to 109,827. (See Figure 2.) Residential populations in 47 states were lowered. The largest percentage reductions were in Michigan (62%), Vermont (54%), Ohio (53%), Nebraska (52%), Arizona (49%), Florida (48%) and Rhode Island (46%), (p. 15). Hill and Lakin (1984) have found that in this period public institutions depopulated at a fairly constant rate of 6,000 residents per year (p. 12).

In considering all types and sizes of facilities, Hill and Lakin (1984) found that the average size of a facility in 1982 was 18 residents. Bruininks et al. (1983) found that the range of public facilities went from one to 1896 beds, with 107,403 people living in institutions having a population over 250.

In the early 1980s state funding for institutions reached a plateau in the United States. At the same time states increased the amount of money spent on community-based services. Figure 3 shows these comparisons in both unadjusted dollar figures and adjusted to 1977 dollars (Braddock, Hemp, & Howes, 1985, pp. 26-31).

Finally, it should be noted that the diffusion of

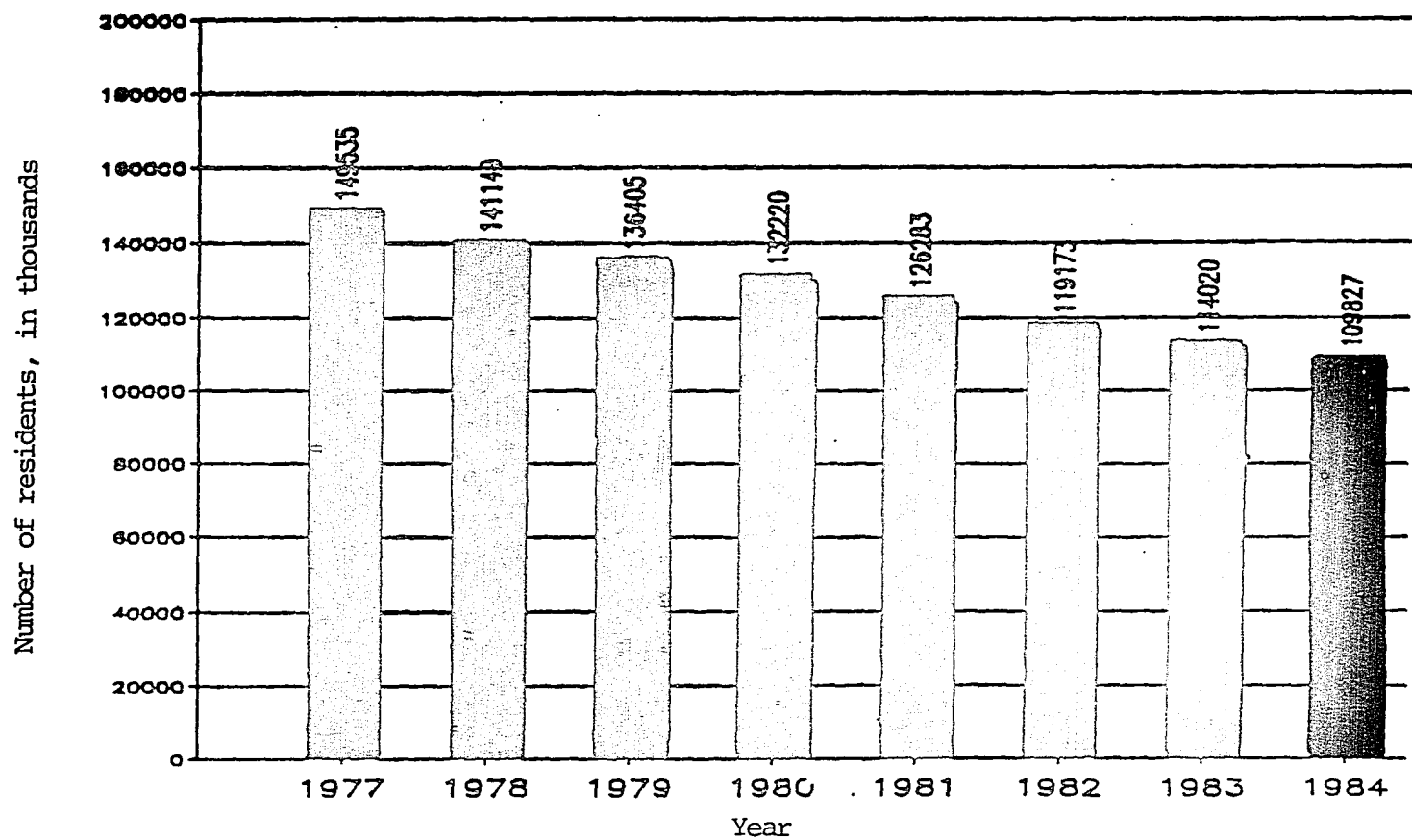


Figure 2. Average Number of Residents in Public Institutions for the Period 1977 to 1984.



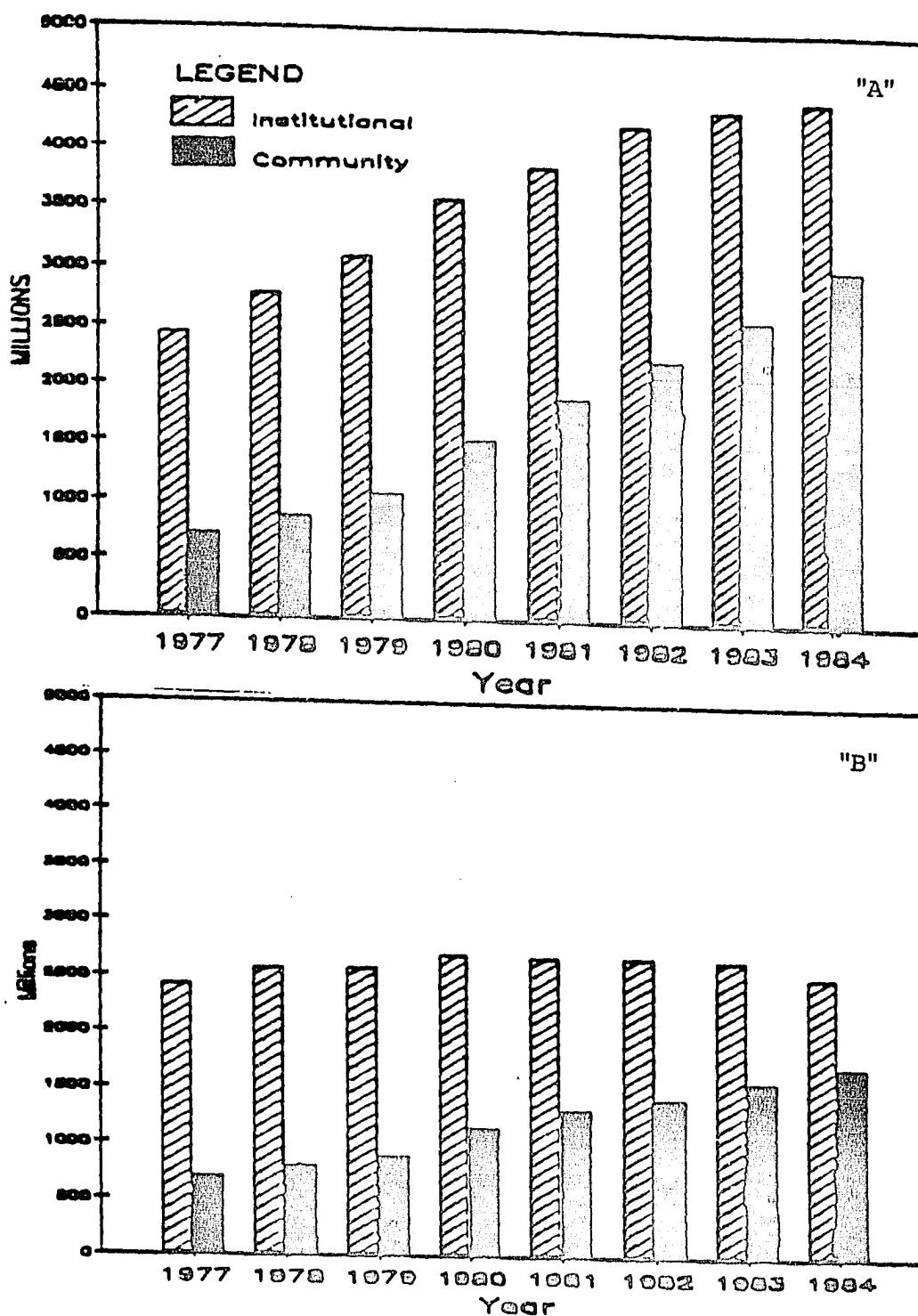


Figure 3. Comparative Annual Expenditures for Institutional and Community Services, in Unadjusted (A) and 1977 Dollars (B).

Federal mental retardation programs continued into the 1980s and is now a part of a broad array of federal programs from health care to housing. However, as a part of these other programs, mental retardation funds are now more susceptible to cutback. This situation did not exist between 1955 and 1980. In real economic terms since 1982, spending for social services for the mentally retarded has fallen by 18 percent (Braddock, Hemp, & Howes, 1985, p. 83).

The 1980s appear to be a period of transition. There is considerable variation in the environments and programs offered among institutions and community living facilities. At this point it cannot be assumed that because much emphasis is currently placed on community living, that superior client outcomes will automatically result. Assessments will need to occur and histories written in 1990 and 2000 will evaluate these changes, in light of the total history of the care and treatment of mentally retarded people.

#### Summary

This chapter reviewed the history of the care and treatment of people who are mentally retarded. History provides the foundation for understanding the development of public policy related to the residential care and treatment of this group in Michigan.

Mental retardation is not an entity that can quickly be defined in terms of shape and substance. This history has shown that its definition depends, at least in part, on the social context in which it exists. In very early times survival was the central interest which often dictated that deformed infants could not be allowed to live. In Greece and Rome, as society became more complex, maintenance of a strong social structure meant permitting the weak and deformed die. Various people advocated for humane care, but were the exception to the rule of the day.

In the Middle Ages, most care was provided at a local level by churches and other religious groups. Late in this period attempts were made to house and train children in asylums and place them in apprentice work as they grew older.

In the 1500s and 1600s the mentally retarded were often considered to be witches and demons. They were persecuted and wandered from town to town. Nor was it uncommon to find the mentally retarded "kept" by the wealthy for entertainment.

The 1700s brought the rise of asylums in Europe. People who were mentally ill and mentally retarded were generally grouped and housed together as "insane" inmates of prisons and almshouses. Only minimal reform was called for during this time.

In the American colonies, care for the mentally retarded was a family or local responsibility. The retarded were often encouraged move to other towns when local charity was stretched too thin. Generally members of the pauper class, they were frequently housed in almshouses. Care in the colonies was a direct reflection of European systems.

In nineteenth century Europe men such as Itard, Esquirol and Seguin contributed to a greater understanding of the mentally retarded. And although laws were developed in western Europe to care for dependent people, living situations did not make great advances. In mid-century, Guggenbuhl opened an institution intending to cure cretinism--something he was not able to do.

Care and treatment of the retarded during the early 1800s in the United States remained a local concern. Communities used systems such as "bidding-off" and "outdoor relief" to care for the poor. In the 1820s, poor houses were constructed in attempts to centralize relief efforts. These facilities became the asylums for a diverse population of poor, criminals, prostitutes, insane and mentally retarded persons.

The reform period before the Civil War was one of humanitarian concern. Initially administrators of experimental schools for the mentally retarded promoted

their work and anticipated success in rehabilitating the majority of their students. In an agrarian society, the mentally retarded were a rather benign group. There was little conflict between their needs and that of society.

At the end of the century, the high aspirations of the experimental school leaders had shifted to the more paternalistic approach of a superintendent. The schools evolved into places to protect the mentally retarded person from an increasingly industrial and bureaucratic society. Xenophobia was common and segregation or isolation became a mechanism for coping with many societal problems.

Administrators became sensitive to the societal demand for restriction and aware of the scientific studies identifying the mentally retarded as the source of national degradation--crime, pauperism, prostitution and illiteracy. The paternal nature of the institution shifted to one of custodialism and separation. At the turn of the century, the mentally retarded had become social pariahs who required complete isolation.

Yet not all mentally retarded people were isolated in state institutions. Even at the height of their growth in the mid-1960s, institutions were able to care for only a minority of the mentally retarded people in the United States. This history shows that social isolation and segregation took place without the walls of

institutions; in schools, the work-place and public services offices.

In the 1960s, care of the mentally retarded focused on securing civil rights and integration into society. The results of these efforts were the depopulation of institutions and expansion of community-based programs.

The history as presented here can not be exhaustive. It is a generalization of the facts about the care and treatment of mentally retarded people over a length of time and a vast array of circumstances. The intent of this chapter was to provide a basis from which to assess the history of the care and treatment of the mentally retarded in Michigan. It provides a foundation from which one can build an analysis of public policy in a single state over a more restricted period of time.

### CHAPTER III

#### CARE IN MICHIGAN: THE EARLY YEARS

To assess the development of policy for residential care of mentally retarded people in Michigan, it is necessary to first understand the historical development of such policy. The purpose of this chapter is to construct a history of Michigan's institutional system.

The concepts established in Michigan will then be compared to those which occurred throughout the United States in the nineteenth and twentieth centuries as presented in Chapter II. It may appear that many of the early provisions made in the state were ideas common to their time across the country.

Principal sources of information used in preparing this portion of the study were laws of the Northwest Territory, session laws of Michigan, and documents of the legislature. Additional information was provided by reports of state asylums and various state and federal census reports. Two other groups offered great insight into the care and treatment of the poor of the era. (A large portion of whom were probably classified as mentally ill or retarded.) County Superintendents of the Poor wrote annual reports detailing the status of the poor. In 1873 this group began holding annual meetings

and providing written accounts in Proceedings of the Annual Convention of the Superintendents of the poor and union Association.

The Board of Commissioners for the General Supervision of Penal, Pauper and Reformatory Institutions (later called the Board of Corrections and Charities) came into being in 1871. It provided biennial reports beginning in 1872. In 1882 this group began holding conventions and printed papers known as the Proceedings of the Annual Conference of County Agents and the Convention of the Board of Correction and Charities.

#### The Northwest Territory

Michigan was part of the Northwest Territory, established separately in 1805. A governor, secretary and three judges constituted the administrative officers of the territory, which had a population of less than 4,000 (Bruce & Eickhoff, 1936, p. 6). Cooley (1885) notes that outside of Wayne county the population was less than 600, mostly French living near Mackinaw and St. Joseph (p. 144).

The first poor relief legislation in the Territory was enacted in 1790. It established the local township as the governmental unit responsible for assisting the poor. It also called for a local overseer of the poor to annually report ass vagrant persons likely to become



dependent upon the township, to notice all distressed families and to inquire about their circumstances (Chase, 1833, p. 175).

A revision of the law in 1795 made relatives liable for their kin and domestic relations. Bruce and Eickhoff (1936) note, "the father and grandfather, and the mother and grandmother and the children of every poor, old, blind, lame and impotent person, or other person not able to work, were required to support those so described" (p. 10). Provisions existed for the sale of property or the jailing of those who failed to support members of their families.

In 1805 Michigan passed an "Act for the Relief of the Poor." Under this act the poor were provided for by contracting with "the person offering the lowest terms for support of such pauper," in other words the lowest bidder. The cost was not to exceed twenty-five cents per day, per poor person (Laws of the Territory of Michigan, 1871, p.91). The final jurisdiction for carrying out these acts was held by territorial justices of the peace.

Revisions of the law in 1809 stipulated a one year residency requirement for property owners, a two year requirement for renters and a three year residency for apprentices before relief could be obtained (Laws of the Territory of Michigan, 1874, p. 40). There was no provision for assisting poor children and disincentives

were established regarding strangers who had not legally settled.

The 1809 law does not clearly explain methods of caring for the poor. Overseers of the poor were to provide houses, nurses and physicians, as necessary. It is unknown if these were to be contracted services or established by local authorities.

An 1817 revision made the sheriff responsible for carrying out relief and conducting the "bidding out" process. This law also added that contractors who failed to perform their duties could be prosecuted. It authorized the court to bind out to apprenticeship all poor children who had no parents to support them (Laws of the Territory of Michigan, 1874, p. 115).

An 1824 amendment authorized outdoor relief in Michigan, giving county commissioners the power to grant temporary relief to residents (Laws of the Territory of Michigan, 1874, p. 185). "An Act in Addition to an Act Entitled 'An Act for the Relief of the Poor'" of 1825 defined residency as living in the territory at the time of its surrender by the British or United States citizenship, in addition to a three year residency. Nor could a person have been "warned to depart" the territory (Laws of the Territory of Michigan, 1874, pp. 287-288). Bruce and Eickhoff (1936) state, "Thus the old English practice of 'warning out' the poor, non-resident

although it was obviously coincident with the system of removal, was here recognized for the first time by statute in the Territory of Michigan" (p. 15). Interestingly, the concept does not appear in later statutes.

In 1827 responsibility for poor relief again shifted. The law stated that "every township in this territory shall support and maintain their own poor" (Laws of the Territory of Michigan, 1874, p. 595). If a person from another township requested relief, two justices of the peace could order the person to return to his previous place of settlement. If he or she did not leave, the constable could be ordered to convey the person to the constable of the next township or county, until the place of legal settlement was reached (p. 596).

In 1829 the Territory established provisions for indoor relief by developing poorhouses. The law allowed for election of a county board of directors to operate a facility for the poor. The labor of those maintained in such houses was to be appropriated by the directors. Although the law did not mandate poorhouses as the only form of relief, where they were built, they were to be the sole method of relief (Laws of the Territory of Michigan, 1874, pp. 728-731). Bruce and Eickhoff (1936) comment that this law and similar ones that followed were enactments to curtail expenditures and reduce taxation

related to the more expensive outdoor relief (p. 19).

It is not clear how many counties actually built poorhouses in the Territory, although the number would have been limited since initial costs were relatively high. In an attempt to control the numbers of people who might live in these facilities, an 1834 law provided that the insane could be housed in county jails (Laws of the Territory of Michigan, 1874, p. 1293).

No records exist to indicate how many of the persons affected by these Territorial laws were mentally retarded. As indicated in Chapter I, no doubt some people with mental retardation were offered outdoor relief, some were bid out to the lowest bidder, some were removed to other counties or townships and some ended up in poorhouses and jails. The significance of the development of Michigan's laws affecting the mentally retarded may not be in the numbers involved as much as the type of system that was created. As will be seen, the poorhouse system was the predecessor of the asylum and state school.

#### The New State

In 1837 the State of Michigan was established bringing with it the relief laws developed in the Territory from a heritage in English and early colonial laws. The principles of these laws were tied to local

responsibility, with townships the major administrative units.

The Revised Statutes of the State of Michigan (1838) directed county superintendents of the poor to report to the legislature the types and cost of relief provided annually. These laws reiterated the liability of relatives and limited the amount of outdoor relief to \$10 per year, per person or family (Section 56).

The first report to the legislature came in April, 1840, from Thomas Rowland, Secretary of State. He apologized because only 23 of the 31 counties had provided the necessary information and assured the legislature he would prosecute those not reporting.

This first status report, found in Joint Documents of the Michigan Legislature (1841) indicates that 522 poor people were being supported by public funds in 1840. Of this number, 260 were children and 367 received temporary relief. The remaining 155 lived in 13 poorhouses scattered throughout the state. Although the laws requested the causes of the poverty, only one category was counted, "number of poor, probably made so by intemperance in themselves or others." This group totalled 300 (pp. 609-611). The significance of the fact that sixty percent of those receiving relief were poor because of intemperance was that intemperance would be linked to insanity and idiocy in coming years.

In 1838 the Revised Statutes of the State of Michigan allowed for land purchases and construction of poorhouses. The amount of land was not to exceed 320 acres and total project costs could not exceed \$7,000 (p. 186). This implied large units, probably farms that could be used to defray some of the facility costs. Bruce and Eickhoff (1936) note that after mid-century, farms were extremely important in reducing costs and providing employment to the able-bodied poor (p. 33).

Investment of public money into land and buildings for the care of the poor set several precedents. First, it influenced decisions related to the construction of state institutions for the mentally retarded. The concepts of large, farm facilities, where those who were able worked to defray costs, had their beginnings in the state poorhouse system.

Michigan's Revised Statutes of 1838 also allowed for the care of mentally retarded persons in county poorhouses. Section 51 of Title IX, Chapter 2, states:

In those counties where poorhouses may be established, the superintendents may provide for the support of paupers that may be idiots or lunatics, out of such poorhouse, in such manner as shall best promote the interest of the county, and conduce to the comfort and recovery of such paupers. (pp. 197-198)

In the early years Michigan governmental officials concentrated their efforts on land development. Governor Alpheus Felch in his 1846 inaugural message said:

The history of our young republic, numbering even now scarcely ten years existence as a State, has been crowded with questions of difficulty and embarrassment. ...They attended upon her early legislation, and taxed the wisdom of all the departments of government in adopting and putting into operation a system which should secure the best interests of the people. (Fuller, 1926, p. 25)

It is obvious that Felch referred to the best interests of the majority. He went on to explain that priorities for the coming years were: building roads, developing common schools, the mining industry and improving railroads.

Fuller (1926) indicates that most of the efforts of the governor, legislature and departments until will into the 1850s, were tied to developing the state as an entity. Governor John S. Barry's speech to the legislature in 1850 was indicative. He discussed the amount of land under cultivation, the amount of produce raised, the number of operating saw mills and the number of cattle, sheep and swine in the state. At the very end of his address, he also noted that a report of the Secretary of State showed 18 deaf, 10 dumb, 71 deaf and dumb, 71 blind and 120 insane persons in the state (pp. 161-165).

In this same year, 1850, the State of Michigan revised its Constitution and recognized the needs of some dependent classes of residents. Article XIII, Section 10 read, "Institutions for the benefit of those inhabitants

who are deaf, dumb, blind or insane, shall always be fostered and supported" (Michigan Manual, 1857, p. 123).

This change in the Constitution was obviously not the first recognition of people with special needs in Michigan. In fact, the first compilation of the Revised Statutes in 1838 had an interesting phrase in the section of rules to be used in construction statutes. The seventh rule states, "The words 'insane person' shall be construed to include an idiot, a non compos, lunatic and distraught person" (p. 2). The mentally retarded were thus considered part of the general class of mental defectives labelled insane. In fact Michigan Statutes Annotated, edited by DeLeon (1980), notes that until 1965 statutory provisions for institutionalization, care and treatment of "feeble-minded" persons were included as part of sections of the law dealing with the mentally ill (Vol. 10a, p. 276).

Documentation of the numbers of people in the state of Michigan who were insane and/or idiotic was a difficult task. First, there was the problem of a very loosely organized data gathering mechanism. As previously mentioned, county clerks were supposed to submit this information, but often did not. In 1848 the legislature made it the duty of the township assessors to tally such when making their assessment rolls. In 1850 this system of data collection accounted for 120 insane



people in Michigan, 10 of whom were idiotic (Joint Documents of the Legislature of Michigan, 1850, p. 4).

The second enumeration problem involved defining the conditions of the people identified. The 1850 report contains the following categories of insanity in which the assessors placed people: insane from infancy, under partial or occasional derangement, monomaniac, religious melancholy, idiotic and other cases. Although these might have been recognized categories by professionals, it is doubtful that township assessors had the training to make proper diagnoses. As late as 1890 a preface note to Statistical Information Relative to the Insane (Michigan, 1891) indicates the on-going difficulties involved in delineating various categories of debilitation. It reads, "The dumb are without doubt in the main idiots, and it is probable that to some extent the epileptic are reported insane and the insane, are perhaps, quite as often reported epileptic" (p. cxxxv). As a note, at the turn of the century the U.S. Bureau of the Census restricted its enumeration to the insane and feeble-minded in hospitals and institutions because of data collection problems (1950, p. 163).

The primary reason the legislature requested enumeration of all insane people was to accompany Public Act No. 187 of 1848. This was the act which established the first asylum for the insane, deaf, dumb, and blind in

Michigan. The original intention was to house all of these groups together in one facility, but the plan was changed in 1851.

Act 187 of 1848 established a Board of Trustees for the asylum, to be responsible for construction and on-going operation. Trustees were also to receive proposals for donations of land, money and materials to build the facility, being told they could do so when proper amounts were donated. Finally, the act stipulated that families would pay the cost of placement at the asylum and if they could not, payment must come from asylum funds (Michigan Public Act 187 of 1848, p. 246-248). It was clearly the legislatures intent not to financially involve the state in this venture.

Sixteen hundred acres of salt spring land, which the legislature thought would be ample for many years to come, were appropriated for sale at an anticipated price of \$57,600 (Michigan Department of Mental Health, 1962, p. 4). Land prices fell and the trustees in their 1851 report noted that, at best, the land was worth \$32,000 (Joint Documents of the Legislature..., 1851, p. 17).

In the same report trustees argued that the legislature's concepts of care for these disabled people were totally inadequate. Recommendations were based on information from other states, fifteen of which had publicly funded facilities. The trustees wrote: "The

great utility of these institutions, and the truly wonderful results in restoring this most unfortunate class to health, has become a certainty" (Joint Documents of the Legislature..., 1851, p. 2).

Arguments were also based on equity with other state expenditures. The board of trustees said:

It should constantly be borne in mind that while we are properly making the most liberal provision for the education of the youth of our State, by establishing institutions of learning of the different grades, there is a helpless and suffering class who have as yet derived and can derive no benefit from these institutions, and whose unfortunate condition calls hourly for relief. (Joint Documents of the Legislature..., 1851, p. 15)

The trustees asked the legislature for an additional \$40,000 to be raised by increasing state taxes, amounting to two and a half cents for each state resident. They concluded their report by reminding the Senate and House that the recently completed Constitution makes "it the duty of the legislature" to provide for such a facility (Joint Documents of the Legislature..., 1851, p. 17).

Regardless of constitutional duty and the reform movement sweeping across the county (see Chapter II) the legislature did not act. In 1853, Governor Robert McClelland reminded decision-makers that nothing had been done for the asylums during the last session. Appropriations were, in his view, inappropriate. He asked for action by saying, "None of our citizens are more deserving of your sympathies, and they cannot be too

strongly commended to your favorable notice" (Fuller, 1926, p. 236).

Yet by 1857, there was still no asylum. Fuller (1939) found that lack of appropriations was the chief source of delay (p. 345). The Biennial Report (Michigan State Asylums, 1857) indicates that several times construction was begun and progressed until funds ran out. Appropriations were inadequate to complete the building, so construction started and stopped several times. The original cost estimates of \$72,000 by then had risen to \$340,000, a fact which trustees defended by showing that costs had not exceeded the average expended by other states.

The Board urged the legislature to take action. They reminded it that many of the insane were in county poorhouses having "the worst possible moral effect" on all residents (Michigan State Asylums, 1857, p. 16) and that the disease of insanity was curable if treatment was properly given (p. 23). They concluded:

The Board of Trustees would express their earnest hope that the institution will at once be completed and opened, and that those enlightened principles of organization and administration which may have formed the basis of the prosperity of many others, will be recognized and acted upon, in order to secure to it a future of the highest measure of success and usefulness. (p. 70)

In April, 1859 the facility admitted its first patient, officially opening in August of that year.

Initially 90 women were admitted. Within a year space was available for 41 men. Three "classes" of people were admitted to the facility--paupers, committed by the Superintendents of the Poor; indigents, by order of the Circuit Court Commissioners; and private patients. Fees for the first two groups were \$2.50 per week, charged to the counties. Private patients paid \$3.00 or more per week "according to the circumstances of the case." The report (Michigan Asylum for the Insane, 1861) concluded, "Under this system it is observed that the State provides for its citizens and institution properly officered, and that current expenses are borne by those directly receiving its benefits" (p. 19).

An interesting view of asylum administration and the meaning of "an institution properly officered" is contained in the Report of the Board of Trustees (Michigan Asylum for the Insane, 1859). In arguing for funds to pay staff they wrote, "Upon the proper organization of the Institution its success solely depends. ...It has been said that a good organization makes good officers, good officers make good attendants, and good attendants invariably good patients" (pp. 18-19). The argument continued, stating that if sufficient funds were not appropriated, the operations of the institution would be embarrassed and average operating costs would increase.

Funds were not granted and Governor Moses Wisner in 1861 chastised the legislature. He said:

The institution has labored under great embarrassments, owing to its not being able to realize the full amount of the appropriations. Such embarrassments will always exist when the Legislature makes appropriations from the General Fund, when that fund is not sufficient to meet the demands upon it. ... It is much the wisest policy to first get the money into the Treasury before you spend it. (Fuller, 1926, p. 387)

The 1868 Report of the Board of Trustees indicated that there was continued need for increased space. A statement is included that reads, "During the nine years which have elapsed since its opening, the Institution has been crowded far beyond its rated capacity" (Michigan Asylum for the Insane, 1868, p. 23). Families, the courts and county supervisors of the poor had all been requesting resident admissions, many of whom waited for long periods of time.

Records show that a total of 808 patients were admitted in nine years. Of this group, 579 had been discharged and 110 died. A report notes that the number of incurables continued to increase thus making fewer beds available. It is not clear how many of the incurable group were mentally retarded. Thirty-two people were classed as imbeciles or epileptics, but idiots were not separately designated (Michigan Asylum for the Insane, 1968, pp. 31-57).

A major supporter of state asylums was Governor

Henry Baldwin, who served for four years beginning in 1869. He encouraged the expansion of farms and was continually concerned that they financially prosper. He also remained aware of the long waiting lists and crowded facilities and urged the legislature to take action. In his inaugural address he stated:

For want of room at the State Asylum, some counties have endeavored to make provision for the insane by building county asylums. In my judgment the necessity for this is to be greatly regretted, both in the light of economy, and what is of far greater importance, humanity." (Fuller, 1927a, p. 30)

Baldwin's ideas about state services for the mentally ill and mentally retarded indicate the shift that had taken place in the twenty previous years since the legislature approved an asylum. There had been a move from emphasis on local, county provision of treatment to state provision. And, as Baldwin said, this was based, at least in part, on economic and humanitarian factors.

Throughout his tenure in office Baldwin expressed the view that all of the "unfortunate class or our citizens" should be afforded treatment available in an asylum. In 1871 he even extended this group beyond those commonly accepted in institutions. He said, "that economy and wise policy also require that the State should without delay provide for all unfortunates, the chronic and the incurable, as well as curable" (Fuller,

1927a, p. 35).

The legislature of this era was looking at methods of improving the growing penal and charitable institution system in the state. Joint Resolution 38 of 1869 established a review commission to study jails, prisons, poorhouses and asylums of the state. The commission was to note which features of these institutions should be encouraged and which should be improved upon, with a view to enhancing the discipline and general management of such institutions. The Commission's final report was to focus on "the manner in which those (the institutions) in this State can be most speedily and substantially improved" (Acts of the Legislature of the State of Michigan, 1869, pp. 422-423).

The Special Commissioners to Examine the Penal, Reformatory and Charitable Institutions of the State of Michigan (1871) report gives great insight into the residential care and treatment of mentally retarded state residents in the 1860s and 1870s. The report on poorhouses contains a sub-section regarding the insane and idiotic. It begins: "There is no chapter in the history of our charitable institutions so fraught with painful and revolting interest, as that which relates to the treatment of the insane and the idiotic in our poorhouses" (p. 14). The commissioners go on to state that these individuals should be wards of the State



because they are utterly helpless, but the asylum at Kalamazoo did not have sufficient capacity.

Existing asylum conditions are best described by the report. It states:

Their condition is for the most part deplorable, and in some instances horrible beyond description. We had read in romance and in history of such modes of treating the insane, but we did not dream that instances of it could be found in our State, and especially in some of our most wealthy counties. Thus, in Calhoun county, we found two insane women and one boy confined in low, dimly-lighted, badly-ventilated cells, which, in winter, could not be properly warmed. In one of them there was no furniture whatever, except a coarse board frame of an old settee without a bottom and an old filthy, long cushion, used alternately as a seat and a bed. Its inmate, a woman, when we saw her, was crouched in one corner of this cage, wrapped in a filthy dress, and glared like a wild beast upon all who looked in upon her. (Special Commissioners to Examine the Penal..., 1871, p. 15)

Recommendations were made at the conclusion of the report for developing five "pauper" classes, of which idiots and the feeble-minded would be one. The report added that these people had been, to date, grouped with the insane and treatment was deplorable. "Language would fail to convey an ideal of their forlorn and utterly hopeless condition," page 74 of the report concludes.

The works of Dr. Samuel G. Howe and Dr. Edward Seguin were used by the commissioners to call for an institution which would provide the necessary care and protection by the State, while giving education and improvement to identified idiots and the feeble-minded.

The commission estimated that about 75 idiots or feeble-minded persons lived in county poorhouses and in the entire state there were probably 1000 idiots (Special Commissioners to Examine the Penal..., 1871, p. 74). It was recommended that provision be made for all of these people because proper care and training could assist a large portion to become useful citizens. It would also prevent them from being led into "evil habits and crime" (p. 76).

In addition to the establishment of an institution for the mentally retarded, the commission recommended a system of central supervision. They concluded that many of the past abuses and problems had occurred because each county or township developed their own administrative system. The commission called for "a supervision that shall extend to all institutions of the same class in the State so that the entire system shall be a uniform and harmonious whole" (p. 90). Although Public Act 192 of 1871 established a Board of Commissioners for the General Supervision of Penal, Pauper and Reformatory Institutions it was not until 1923 that institutions for the mentally retarded and mentally ill became part of that system.

The report of this 1870 commission served to bring to light the situation of the mentally retarded in Michigan. It called for their education and highlighted the fact that seven states had already established

institutions for this purpose. However, it would be several decades before Michigan would establish its first public school for the feeble-minded.

Records indicate that Governor Henry Baldwin continued to press the legislature for assistance to distressed groups. In 1872 he asked for laws to protect against forced confinement in state asylums, the establishment of a state public school for dependent and neglected children and development of a system to place children with families when they were neglected or orphaned. His concern for children related to the fact that superintendents of the poor reported that 529 children under the age of 16 resided in poorhouses, 40 of whom were deaf-mutes, idiotic or insane. He said, "I do not hesitate to express my firm conviction that it is the dear duty of the State to provide for the care and treatment of all its people thus afflicted" (Fuller, 1927a, pp. 129-130).

Governor John Bagley took an even more paternalistic view, saying in 1873 that it was the duty of the state to exercise the same care that a parent would over "his" children. In arguing for more asylum space he admitted that construction was costly but such buildings had a positive result. He said, "They stand forth as enduring monuments of Christian charity and loving care of our people, for the unfortunate among them" (Fuller, 1927a,

p. 163).

Bagley addressed the needs of the idiotic in state poorhouses by proposing that a special unit, designed to house the mentally retarded, be added to a new asylum. The Kalamazoo asylum had reached its capacity of 550, as large a number as should ever be placed in one institution according to the Governor, and other plans had to be made. He said:

If you should decide to take action regarding a new asylum, provision might be made for these 'babes of God' in the same structure. I most sincerely hope it may be not long before we will be enabled to empty every poorhouse and jail in the State of its insane and idiotic inmates" (Fuller, 1927a, p. 163).

Poorhouses and other accommodations for the insane and idiotic varied greatly from county to county. The report of the Kalamazoo Superintendent of the Poor describes one of the better facilities. He wrote:

Our poorhouse is old but comfortable. ...The Kalamazoo--a noble river--bounds our domain on the south, and being but sixty rods from the house, all but the sick, infirm and lazy can bathe without cost to the county; the excepted paupers have no facilities than rain-water, soap, and a washcloth afford. ...For the insane and idiotic, we have rooms with grated doors for those that are incurable, turbulent, and unsafe; all curable cases are sent to the Asylum immediately for treatment. (Superintendents of the Poor, 1872, p. 48)

Ingham county's 1872 report reflects a different situation. In part, it states:

The first impression of intelligent observers would be, so far as the males' house is concerned, that the parties who designed and built it had just emerged from caves, holes in the ground or bark

huts, upon which it is a slight improvement. ...If the State or the Lord would swell the heads of some of our Supervisors and Superintendents large enough to hold a good-sized idea, we might hope in the future to have respectable buildings and accommodations. (Superintendents of the Poor, 1872, p. 46)

The Board of State Commissioners for the General Supervision of Charitable, Penal, Pauper and Reformatory Institutions (1875) documents that state poorhouses, and occasionally jails, housed numerous mentally retarded people. It notes that one county had a supplementary building called the "Fool's House" that held only idiots, including at least five children (pp. 44-45).

The commissioners recommended that until the state was willing to establish a separate asylum for the mentally retarded, a district almshouse should be designated to make special provision for them (p. 47). Based on information from Massachusetts, the commission proposed that the mentally retarded could be educated and trained. They cited a report from France that claimed 40 percent of those trained had been rendered capable of deportment and work equal to two-thirds of a man, and 25 percent came near the average standard. The Commission summarized Michigan's status by adding, "It is probably true that in this State we have not yet produced the equivalent of two-thirds of a man from all idiots treated in twenty-five years" (pp. 47-48). No record was found in the course of this research to indicate that such a

facility was ever established.

The asylum for the insane at Kalamazoo continued to expand and evolve as a significant institution in Michigan. The Michigan Asylum for the Insane (1877) report indicated legislative appropriations and subsequent expenditures for a laundry department, a house for the gardener, porches, fire apparatus, fencing, medical equipment, and other construction (pp. 8-22).

The goal of the asylum was still focused on curing people and returning them to society. The medical director stated in the 1877 report, "The aim in all institutions for the insane should be to secure restoration and to promote the comfort and mental and physical welfare of patients to the greatest possible degree" (Michigan Asylum for the Insane, 1877, p. 117). Even though the Kalamazoo institution was over-crowded and expanded to a size not originally intended, legislative appropriations and reports of the staff are evidence that the institution was still patient-oriented.

In August, 1878, 220 patients were transferred to the new Eastern Michigan Asylum in Pontiac, originally authorized in 1873. Optimism about the effectiveness of these two state hospitals, with a total bed capacity of 900, was reflected in Public Act 194 of 1877. Section 49 states:

After the Eastern Michigan Asylum shall have been

opened for patients, and room shall be sufficient for all the insane wards of the State, then and thereafter it shall be illegal for county superintendents of the poor or for any other authority whatever to consign to the county almshouses any insane person. (p. 226)

The Michigan Asylum for the Insane (1879) report praised this legislative effort, asserting that this would allow admission of the less disturbed and earlier treatment. The report states: "In this way the ratio of recoveries will undoubtedly be increased, and the expense of support ultimately reduced" (p. 15). Yet by October, 1880, the population of the two facilities was already 1082, 182 over capacity (Michigan Asylum for the Insane, 1880, p. 5).

In his message to the legislature in January, 1881, Governor Charles Croswell noted that both asylums were over-crowded and that requests had been made to expand them and construct a third institution. He was opposed. He said:

This will involve the outlay of half a million dollars, an expense which I cannot make myself believe is absolutely necessary. Many of the insane in our Asylums are harmless and inoffensive imbeciles, who cannot be cured, and who could be kindly cared for at their homes, or in the counties from whence they came, at a mere nominal expense compared with the cost of providing for them by means of a new Asylum. ... I am of the impression that the demand for more room may be humanely met by suitable provision through which this imbecile and harmless class may be provided for among their friends, if need be, at the public expense. (Fuller, 1927a, p. 349)

The legislature did not act upon the Governor's

suggestion of providing home care for imbeciles. Instead Public Act 225 of 1881 provided for location, establishment and organization of an additional asylum for the insane (p. 267). An appropriation of \$400,000 was authorized, but proved insufficient. The Northern Michigan Asylum in Traverse City did not open until November, 1885 (Department of Mental Health, 1962a, p. 44).

At about this same time, asylum superintendents began asking for separation of the criminally insane from the general hospital population. The various Boards of Trustees convinced Governor David Jerome that this group was a problem because of their disruptive nature and the security risks they posed. As a result, in 1883 the Governor recommended constructing a new facility for convicted criminals classified as insane. The new institution would be based on similar programs in neighboring states, as well as institutions that had positive results in several European countries. The outcome was Public Act 190 of 1883 which authorized erection of the Michigan Asylum for Insane Criminals at Ionia, which opened in 1885.

By 1885 Michigan had four institutions for the insane. Since the first one had accepted patients in 1859, these asylums had served approximately 7,000 people. They established farm systems to raise produce



and employ residents, and developed a farm colony to lower the cost of caring for the chronically mentally ill (Board of Corrections and Charities, 1887, pp. 5-10). The state had also grown. The 1884 census counted more than 1.8 million state inhabitants; 2644 of whom were listed as insane, 1527 as idiotic and 1137 as epileptic (Michigan, 1886, pp. 460-466).

During this period, no provision has been made for the mentally retarded on a state-wide basis. As mentioned previously, recommendations had been made by governors, local superintendents of the poor and the Board of Corrections and Charities, but no action had been taken. Generally the mentally retarded were housed and treated with the insane or in poorhouses. In either case they tended to be classified as chronic wards of the state. Attempts were made, however, to remedy the situation. As an example C. T. Wilbur, Director of the Illinois institution for the feeble-minded, spoke to the Michigan legislature on "Idiocy and the Treatment of Idiots", March 15, 1877. He was accompanied by G. D. Gillespie, Bishop of the Western Diocese of Michigan and member of the Board of Corrections and Charities. Mr. Wilbur urged legislators to establish a separate institution for the education of the mentally retarded (Journal of the House of Representatives, 1877, pp. 899-900). In that same year the Commissioners of Penal,

Reformatory and Charitable institutions also called for a separate asylum to educate the feeble-minded. They reminded the governor that to comfort the feeble-minded was a "sacred obligation" (Board of State Commissioners for the General Supervision of Charitable, Penal, Pauper and Reformatory Institutions, 1875, p. 22).

Apparently in response to the lack of effort by Michigan officials, Wilbur established a private school and home for feeble-minded children at Kalamazoo in 1884. The Board of Corrections and Charities (1887) stated that the facility was designed to accommodate nervous and backward children and youth whose families could privately support them (p. 132). The same report from 1884 added that the new institution would offer an alternative for families:

It is for families who prefer to have their children kept from association with the pauper inmates of the State institutions, and especial pains will be taken to furnish better accommodations, more privileges, better diet, and more personal and individual care and attention than can be bestowed upon the large number usually congregated and crowded into the State or public institutions. (Board of Corrections and Charities, 1884, p. 252)

Michigan did not have a public facility for mentally retarded people, but by 1885 it had a private one that planned to accommodate up to 75 individuals.

The Board of Corrections and Charities continued to request that the governor and legislators take action. The lengthy passage which follows summarizes the view of

the mentally retarded of the day. They were considered unfortunates, a disgrace and burden to families, but could be trained given the proper setting. The recommendation for legislation was as follows:

Another matter of deep importance and which for some reason has not received the attention of the public that it should, is the question of the care of a very large and increasing number of unfortunates call idiotic or feeble-minded. Children of this class are to be found in the homes of the well-to-do and wealthy, as well as in the houses of the poor, and in the poor-houses. It is very difficult to ascertain the number, because the existence of such a child is considered a disgrace, and it often happens that the most intimate personal friends of the family have no suspicion even of the existence of such a child in the house. Of course the family has neither the means nor knowledge to properly care for or train such a child. The existence of such a child is a nightmare to the parents, and a curse to the family. The welfare of the family alone should dictate that such a child be removed to some place where it can be properly nurtured and trained. A very large percentage of even the worst of this class can be sufficiently trained to take care of and feed themselves if under proper treatment. The members of the Board have seen specimens of this class in the poor-house of this State which, if known to the people, would arouse a feeling that would compel some State provision. It is the one thing in which the State of Michigan is far behind, and the longer continuance of this lack of provision for the feeble-minded will be a continual disgrace. (Board of Corrections and Charities, 1887, pp. 103-104)

Discussions on care of the mentally retarded also increased in professional circles during this time. In 1884, F. P. Anderson, M.D., (1885) made a presentation to the County Agents of the Corrections and Charity Board explaining the need for state care. He noted that, "Idiocy is arrest of development; imbecility is

impairment, degeneration. ...An idiot may become imbecile, and innocent may become savage" (p. 34). To prevent deficient children from becoming unruly and malignant Anderson (1885) stated that proper education was necessary and that the State of Michigan should provide it in an institution. Such a facility would be multi-purpose. He said, "An institution under competent persons shall give us aid in the general search of science for causes, cures, preventatives, as well as forming citizens" (p. 35). This was the original concept of an institution for the feeble-minded in Michigan.

Parents also expressed their desires for such a facility. One mother wrote:

I have a little daughter, beautiful of face and form, and yet with that "missing link" that debars her from the common school. ...I have a little taxable home, my labor pays these taxes that go to support systems and institutions from which my own helpless and unoffending member is excluded! I ask for one more--a Training School for the Feeble Minded, that they may be so reached as to share with other wards of the State in the elevation. (Gillespie, 1887, p. 89)

Bishop Gillespie received other letters of entreaty describing mentally retarded people of various ages and conditions. One mother told of her nine-year-old son whom she could not control, another of an 11-year-old girl who continually banged her head on the floor and needed constant supervision. Others spoke of adults living with these older parents and relatives. Gillespie

(1887) used these examples to continue to urge state action. He said, "Shall not our noble Michigan gather to her arms, with her blind, her deaf and dumb, the children of a greater deprivation" (p. 93).

The argument "children of a greater deprivation" may have created a portion of the problem. Services for the mentally retarded were in competition with state prisons, reform schools, insane asylums and numerous other public projects. Evidence is seen in Governor Cyrus Luce's 1887 request for appropriations. He detailed the progress and needs of the various state programs and presented a budget. Immediately following the request is a three sentence insert about an institution for the care and education of the feeble minded. No appropriation is recommended, just a reminder that their "unfortunate condition commends them to the sympathy of the humane" (Fuller, 1927a, p. 577).

That year, 1887, a bill was submitted to the legislature for the education or training of the feeble-minded. Wheeler (1888) noted it included only those capable of being taught and trained. He added, "This bill received no consideration, excited no interest, was absolutely ignored" (p. 72). He stated that part of the reason for the bill's failure was that each charitable institution had a local board pressing for funding and jealous of the criticisms of others.

Bishop Gillespie added that a second problem was that legislators did not understand the penal and pauper systems of the state. He said, "The great difficulty is the want of intelligence on the part of the Legislature. ...Often the gentlemen who are elected to the Legislature have not much time after election to visit the State institutions and study up on this subject" (Wheeler, 1888, p. 77).

Interestingly, in an apparent attempt to remedy both the problem of divisiveness within the organization and public education, the Board of Corrections and Charities passed the following resolution:

Whereas, The wide diffusion of knowledge and the rapid increase of wealth continue to make more and more complex and difficult the various problems of social science; therefore

Resolved, That in a free commonwealth, it is the imperative duty of every good citizen to take an intelligent and active interest in all measures looking to the amelioration of the condition of the unfortunate classes; the deaf, the dumb, the blind, the imbecile, the insane and the orphaned, and to see that the State makes adequate provision for their care and comfort. (Board of Corrections and Charities, 1888, p. 106)

This Board became the chief advocates for the establishment of an institution. Each year they sent resolutions to the governor and legislature. Each year the rhetoric of convention speeches became more pointed. An example of this is S. P. Sutton's (1889) paper. He asked, "Why stand we here idle? The eye of the Master is

upon us" (p. 104). He said Michigan had done nothing and the state should be ashamed. He asked, "Should we go back to that age when Solon the great law maker gave parents the right to kill their unwelcomed children? Plato and Aristotle endorsing the horrible practice. Banish the thought! It cannot be!" (p. 104).

Forrest (1890) notes that a bill was introduced in 1889 to establish a home and training school for feeble-minded children between the ages of six and twenty-one. It was to be an experimental school to ameliorate their condition and return residents to a useful role in society. An appropriation of \$12,000 was requested for 1889 and \$15,000 for 1890.

The bill passed the House by a vote of 52 to 34. In the Senate the Committee on Finance and Appropriations recommended that the bill not pass. It was tabled and never came to a vote (Forrest, 1890, p. 44). The reason for this action is not clear, but may have been related to fears of overly large state expenditures. In May, 1889, Governor Luce wrote the House of Representatives warning of increased expenses for the care of the insane. He stated that asylum budgets would soon surpass the one million dollar mark (Fuller, 1927a, p. 621). Judge Levi Barbour commented at the Association of County Agents Convention, that one legislator told him that the legislature could not address all the social acts placed

before them and would have to limit themselves to one or two (Forrest, 1890, p. 46).

Judge Barbour, in the same speech, offers some insight as to why persons with mental retardation needed institutionalization. He noted the number of poorhouses and the number of individuals who were a severe burden to their families. He also noted the economic benefits for the State created by a centralized institution as opposed to other relief systems. He then added two other reasons for developing such a facility. He stated: "They require separate care ... that they should be kept out of harm's way. It has never been enjoined on them to multiply and replenish the earth" (Forrest, 1890, p. 46). This thinking represented the early concepts of segregation to protect the mentally retarded, and keep them from procreating.

#### The First Institution (1895)

After urgings from the Board of Corrections and Charities, parents and Governor Edwin Winans, the legislature enacted Public Act 209 in 1893. This was an act to establish a home and training school for the feeble-minded and epileptic. In 1894, \$50,000 was appropriated for construction of the institution and \$15,000 for operations (p. 414).



### The Law

Public Act 209 of 1893 directed that all feeble-minded and epileptic children between the ages of six and twenty-one be admitted to the new facility without charge. Preference was to be given to paupers, orphans and the indigent in an attempt to lessen the demand for care at state poorhouses. The stated purpose of the institution was in keeping with the ideas and concepts that had been proposed for more than twenty years. Section 21 clarifies:

The object of said institution shall be to provide, by all proper and feasible means, the intellectual, moral and physical training of that unfortunate portion of the community who have been born or by disease have become imbecile or feeble-minded or epileptic, and by a judicious and well adapted course of training and management to ameliorate their condition and to develop as much as possible their intellectual facilities, to reclaim them from their unhappy condition and fit them as far as possible for future usefulness in society. (State of Michigan Public Act 209, 1893)

Legislative intent was that this institution would ameliorate the feeble-mindedness of its residents and return them to society. But by this time, nationally, the concept of educating the mentally retarded was no longer in favor and it appears that the Board of Control of the Michigan Home for the Feeble-Minded followed the national trend instead of the ideals held in the enabling legislation.

Even before the institution opened, amendments to

the original law were offered that made two changes (State of Michigan Public Act 235, 1895). First, the upper age limit of twenty-one years was dropped, a change which allowed individuals to be kept at a facility for an unspecified period of time. Second, a phrase was added requiring parents to pay for care if they were able. Storrs (1896) expressed his concern that this was against the charitable nature of the facility and that it might also be used to discriminate against the poor. Additionally, he argued that the process taxed the family twice; first through state taxes and second through payments (p. 51).

#### The Population

The concepts of segregation and protecting society from the mentally retarded person clearly existed in Michigan. In late 1892, Levi Barbour (1893), a member of the State Board of Corrections and Charities, in late 1892, told a conference that few feeble-minded persons could learn to provide for themselves. If not institutionalized the retarded would become helpless paupers. He added, "The girls of this class, if discharged from the institution, soon become the prey of unscrupulous men, and their offspring are in the great proportion of cases, either feeble-minded or in some way defective" (1893, p. 86). Barbour concluded that in

institutions for the feeble-minded many difficulties of the person, their families, and society could be avoided.

Loren' Sherman in an 1894 speech entitled, "What We Propose to Do in, and What We Expect from Our Home for the Feeble-Minded and Epileptic" indicated even stronger views about the mentally retarded. He first stated that the institution would be built on the cottage plan with plenty of land for farming because productive labor was the best treatment for the residents. He added, "Education for its own sake was wasted upon children of feeble intellect" (p. 81).

Secondly, Sherman added that large amounts of land would allow for the separation of males and females. He contended that the sexes should be kept separate and not even allowed to see each other. Thus preventing potentially immoral and corrupting behavior.

Thirdly, Sherman stated that the laws needed to be amended so that the feeble-minded and epileptic would become wards of the state. This would remove the burden of such children from families and give the state the power to make necessary decisions about the care and treatment of each child.

He concluded that a home and training school would (1) relieve the state of promiscuous associations among the feeble-minded, (2) provide productive labor and (3) limit the production of future generations of like

unfortunates. It will be seen that these concepts would eventually become the major forces behind the Michigan institution system and sources of future problems for the system.

### The Programs

The Michigan Home for the Feeble-Minded and Epileptic opened in August, 1895 near the village of Lapeer. The general plan of the facility was designed to accommodate 800 to 1,000 feeble-minded people and an equal number of epileptics. In the first year, two cottages were built with a capacity of 100 persons each. These were filled almost immediately and the Superintendent, W. A. Polglase, M.D., reported a waiting list of 600 within a few months of opening. This number increased by an average of 25 applicants a month by mid-1896 (Michigan Home for the Feeble-minded & Epileptic, 1896, p. 9).

Polglase (1897) notes that the institution was divided into units of 25 with one attendant watching residents at all times. He states, "Every habit of life is regulated, directed and helped to conform to the best type of physical, mental, and moral perfection possible with a defect; the purpose being to promote usefulness and contentment" (p. 11).

Interestingly, the superintendent seemed to be

addressing human usefulness in the context of the institution and not in the outside world. He concluded his report with the comment that it was wise to care for the majority of the feeble-minded for life. Only a small minority, he stated, could be discharged safely to their own control or that of friends (Polglase, 1897, p. 11).

To support these contentions the Board appended statements from such experts as George Knight, Walter Fernald, and Martin Barr regarding the incurable, mischievous and promiscuous nature of the mentally retarded person (Polglase, 1897, pp. 26-32). Each anecdote portrayed the retarded as needing such an institution.

Therefore, within months after the opening of the home and training school, treatment emphasis began to shift from amelioration to isolation. Certainly such changes were occurring through the nation (see Chapter II), but only in a few places did they take place so rapidly.

Demands for additional bed capacity would continue throughout the years to come. In 1897, retiring Governor John T. Rich reminded the legislature of this ongoing need. He argued for increased appropriations based on economy of scale and the public good. He said:

After the necessary buildings are completed, and experience is gained in their training, the expense of maintaining them will be less in a State

institution then in the poorhouses and they will not be left as a burden on their friends or as a plague to society (Fuller, 1927a, p. 748).

The Report of the Board of Control (Michigan Home for the Feeble-minded and Epileptic, 1898) expressed similar concerns. Even though expansion funds were being requested, the work was being done, according to the Board, in the most efficient manner. The report states, "The Superintendent's report shows definitely, and in detail, the work accomplished by the institution in its various departments and the carefulness, economy and efficiency of the general management" (p. 6).

Governor Hazen Pingree in 1897 urged the legislature to investigate all state institutions of charity to assure that they were being run with utmost efficiency. He said, "Economy in their management should always be practiced, but the necessity of reducing the cost of maintenance, if possible, was never more keenly felt than at present" (Fuller, 1927b, p. 37). Although Pingree proved to be supportive of charitable institutions, he continued to stress economy throughout his administration.

While state-level decision makers pressed for the stabilization of costs, demands continued to mount for institution placements. At the turn of the century, Dr. Polglase reported that there were a total of 1,014 applicants for admission since the Home opened four years

earlier, and a waiting list of over 700. He estimated that there were 7,000 feeble-minded and epileptic people in the state and that less than five percent were presently in the Home (Michigan Home for the Feeble-minded and Epileptic, 1900, p. 8).

Polglase proposed utilization of the "colony plan" to serve more people in a less expensive manner. He was convinced this would be absolutely necessary in coming years as individuals became more aware of the problems the mentally retarded created in the community. He said, "There are in the community a class of physical and mental defects, whose liberties must in some way be curtailed in order to prevent the increase of these dependent human weaklings" (Michigan Home for the Feeble-minded and Epileptic, 1900, p. 8).

In summary, the formative years of the Michigan Home and Training School for the Feeble-Minded and Epileptic, saw a rapid shift from the concept of amelioration of mental retardation to a concern for providing long-term care in isolation from the general public. The Board of Corrections and Charities (1901) report for funding for items that would make the institution more self-sufficient, independent, isolated and permanent. Requests included new custodial and administration buildings, a house for the superintendent, a farm house, herd of cows, cow barn, auditorium and root cellar

(pp. 25-34). The facility had become a permanent part of the state charitable institution system.

#### The Expanding Institution (1900-1920)

As the twentieth century began, the Board of Control and superintendent of the Lapeer facility, continued to request appropriations to increase resident capacity. The institution housed 210 people in its first year, 282 in 1900, 650 in 1905, 968 in 1910 and 1266 in 1916. In two decades the population grew to six times the original number. Much of this increase and continuing demand came because of a changing perception of mentally retarded people. They were no longer the amiable, trainable people depicted in early legislation; but had become linked with many of the social ills of the day.

This trend began in Michigan just before the turn of the century and was based on evidence presented nationally by men like Fernald and Barr, as mentioned in the previous chapter. Nor was this menacing view of the feeble-minded person fostered by ill-advised people. An example is a speech given to the Association of County Agents in 1897 by Dr. W. A. Polglase, superintendent of the Michigan Home and Training School and, therefore, one of the leaders in the field.

Dr. Polglase (1897) began his speech by stating that there was no more pitiable object than feeble-minded



persons left to fend for themselves. He stated, "The causes of imbecility are somewhat varied, but no one will dispute for one moment the great part played by heredity" (p. 92). He then added that the two conditions in parents which produce feeble-mindedness in their offspring are neurotic diseases and inebriety.

In closing, Polglase (1897) suggested his solution to the problem. He said:

No greater question can be considered in political economy than of life long detention of a large majority of all imbeciles and especially so of the so called moral idiot. Under strict unceasing surveillance, constant, congenial employment and happy environment, many of them will contribute largely to the community of which they are members, their sequestration preventing production and reproduction, preserving the nation from a flood of the worst type of imbecility and crime. This thing ought not so to be, it is too wildly expensive, and America is too young a country, with too much good rich blood in its arteries to allow the admixture of this taint; we should and ought to represent the highest type of healthy mentality. (p. 97)

Life-long detention because it was best for the feeble-minded and the society would become the tenor of laws, for thirty the next years in Michigan.

### The Laws

At the turn of the century, heredity was considered a common cause of mental retardation. Likewise, idiocy was seen as one of the major causes of pauperism in the state. In 1890, reports listed idiocy as the number one cause for confinement of people in poorhouses in Michigan

(Superintendents of the Poor, 1891, p. 16). Ten years later it ranked as the fourth cause behind sickness, unemployment and insanity (Superintendents of the Poor, 1902, p. 18). To control this problem a series of were enacted.

Public Act 136 of 1905 expanded a law that had existed from the early days of statehood. The original Act (Revised Statutes of the State of Michigan, 1846, Chapter 84) voided any marriage solemnized in the state if either party was insane or an idiot. The pertinent portion of the amended act expands on this concept. It states:

No person who has been confined in any public institution or asylum as an epileptic, feeble-minded, imbecile or insane patient shall be capable of contracting marriage without, before the issuance by the county clerk of license to marry, filing in the office of the said county clerk a verified certificate from two regularly licensed physicians of this State that such person has been completely cured of such insanity, epilepsy, imbecility, or feeble-mindedness and that there is no probability that such person will transmit any of such defects or disabilities to the issue of such marriage. Any person of sound mind who shall intermarry with such insane person or idiot or person who has been so confined as an epileptic, feeble-minded, imbecile or insane patient in any public institution or asylum, except upon the filing of certificate as herein provided, with knowledge of the disability of such person, or who shall advise, aid, abet, cause, procure or assist in procuring any such marriage contrary to the provisions of this section shall be deemed guilty of a felony and on conviction thereof in any court of competent jurisdiction shall be punished by fine of not more than one thousand dollars or by imprisonment in the State Prison at Jackson not less than one year nor more than five years, or by both such fine and imprisonment in the

discretion of the court. (p. 186)

In other words, people who were mentally retarded could not marry and for another person to marry anyone who had been a resident of a state institution was to risk imprisonment and/or fine.

An even harsher law was proposed during the 1897 session of the Michigan legislature. Section 1 of the bill stated that all residents of the Michigan Home for the Feeble-minded and Epileptic would be reviewed by a three physician panel to determine the advisability of an asexualization operation. This would be to assure that "such person or persons shall cease to reproduce their kind" ("Asexualization of Criminals and Degenerates," 1897, p. 289). Other sections proposed similar treatment for rapists and habitual criminals. Representative W. R. Edgar, M.D., introduced the bill because he was alarmed that the state would have to care for a large number (3218 by his count) of mentally retarded people. Citing that only 6,000 of an estimated 90,000 feeble-minded persons were institutionalized in the United States, Edgar claimed that the remainder were free to marry their own kind. He conjectured, "We can readily form a picture of the condition of society a few generations hence" ("Asexualization of Criminals and Degenerates," 1897, p. 293). The bill passed the House of Representatives but failed in the Senate by 6 votes.

It should be noted that there were those who voiced opposition to the legislation. Charles Hitchcock, M.D. stated, "Asexualization of degenerates would fail utterly of its object, were such a step attempted before public sentiment has been so educated as to demand such extreme means for the preservation of society as against the individual" ("Asexualization of Criminals and Degenerates," 1897, p. 305). Hitchcock, and others, believed that such an enactment would be a detriment to the state of Michigan.

However, 16 years later, Public Act 34 of 1913 authorized sterilization of mentally defective persons maintained wholly or in part by public expense in state institutions. The boards and physicians of institutions were empowered to approve vasectomies or salpingectomies for facility residents. Parents or guardians were to be informed of the decision and then had thirty days to appeal to the Probate Court.

The judge of probate would then decide the advisability of the operation. Laughlin (1922) notes that the legislature's motives in passing this bill were both eugenic and therapeutic (p. 11). He added that the bill passed by large majorities--72 to 16 in the House and 21 to 9 in the Senate. Governor Ferris signed the bill into law in April, 1913. In June, 1913 the Governor in speaking to the meeting of the American Association

for the Study of the Feeble-Minded stated that he thought that ridding America of its social ills by sterilization was an extravagant claim (Ferris, 1913, p. 71).

The law was challenged by the guardian for Nora Reynolds a thirty year old resident of the Michigan Home and Training School. Nora Reynolds had been placed at the Home when she was twenty-four years old. In 1909, she escaped and was pregnant when she returned. In 1912, she escaped several more times with the assistance of the night watch for her cottage and again became pregnant. (The night watch was later convicted of having carnal relations with Ms. Reynolds). Based on this history, staff at the facility recommended her sterilization (Laughlin, 1922, p. 305).

In 1918, the law allowing involuntary sterilization was found to be unconstitutional by the State Supreme Court. Since it only applied to those in state institutions, the law denied equal protection to feeble-minded individuals in the population at large (Laughlin, 1922, p. 203).

Public Act 285 of 1923 and Public Act 281 of 1929 authorized sterilization of all mentally defective persons and were intended to "prevent the procreation of feeble-minded, insane and epileptic persons, moral degenerates, and sexual perverts" (State of Michigan Public Act 281 of 1929, p. 689). Section 1 of the latter

act states:

It is hereby declared to be the policy of the state to prevent the procreation and increase in number of feeble-minded, insane and epileptic persons, idiots, imbeciles, moral degenerates, and sexual perverts, likely to become a menace to society or wards of the state. The provisions of this act are to be liberally construed to accomplish this purpose. (p. 689)

The law not only allowed for the involuntary sterilization of the mentally retarded, but grouped them with the insane, moral degenerates and sexual perverts. In other words, they were considered part of the deviant class in Michigan society. Authorization to sterilize remained part of state of Michigan statutes until 1974.

Public Act 150 of 1913 created a commission to investigate the extent of feeble-mindedness, epilepsy, insanity and other conditions of mental defectiveness in Michigan. The commission was made up of the Director of the State Psychopathic Hospital, the Secretary of the State Board of Health, the Superintendent of Public Instruction and the Secretary of the State Board of Corrections and Charities (p. 262).

Regarding the feeble-minded, Commission staff studied two areas. First, they made a determination of the extent of feeble-mindedness and factors related to it at the reform schools for boys and girls. Second, they examined the inmates of county infirmaries to determine the prevalence of feeble-mindedness in those facilities.

(Commission to Investigate the Extent of Feeble-mindedness, Epilepsy and Insanity and Other Conditions of Mental Defectives in Michigan, 1915, p. 10).

Commission members began the study with a bias regarding hereditary influences. Their introduction states, "Goddard, Davenport, and Tredgold agree that in at least 80 percent of the cases of feeble-mindedness, heredity is the dominant cause. ...The consensus of opinion is that the Mendelian law is in the main applicable to the inheritance of feeble-mindedness" (p. 43).

The Commission's findings also paralleled much of the eugenics thought of the day. In relation to the feeble-minded they found:

1. Juvenile delinquency and feeble-mindedness were closely interrelated.
2. The mentally defective were less reliable in occupational settings.
3. Feeble-minded delinquent girls were more sexually irresponsible than normal delinquents.
4. The presence of backward and defective children in school retarded the progress of other children.
5. Dependency on the state welfare system and mental defectiveness are closely interrelated.
6. Feeble-minded women, both married and unmarried, added large numbers to the State's dependent

defective classes.

7. Until provisions were made for the care of the feeble-minded, especially women of child-bearing age, feeble-minded come for the Feeble-minded and Epileptic, 1913) noted that the problem with the system was that Probate Judges were only committing those who were in greatest need of care, the epileptic and persons of "low grade". The report continued, "This system does not take from the community those most dangerous to society, for we know only too well the high grade imbecile are the type who reproduce their kind, and are, therefore, the real menace to the public" (p. 8).

The second law change is mentioned in the Board of Control's 1914 report. The Board asked the legislature for a new name. "They complied and re-christened us as the Michigan Home and Training School, giving us a name, we believe, with all semblance of a sting removed" (Michigan Home and Training School, 1914, p. 58).

It is interesting how the name of the institution evolved. For the first seven years it was referred to by the as the Michigan Home and Training School for the Feeble-Minded and Epileptic. In about 1900 the phrase "training school" was dropped. There is no indication as to why this occurred, but at about this time the facility emphasis moved toward permanent care. Training, as originally defined, no longer considered a priority.



The 1913 name change, signalled another subtle shift. Although the words "Training School" were again added, the words "for the Feeble-Minded and Epileptic" were deleted. The only indication of the reasoning behind this change is the quote already noted -- the semblance of a sting was removed.

Despite these efforts, the public image of Michigan Home residents was transformed from positive to negative as the Michigan Home and Training School grew. The following section will address how this image developed and the effects that it had upon the mentally retarded people of the day.

#### The Population

As discussed in the previous chapter negativism toward the mentally retarded reached a high point nationally after the turn of the century. The professional debates regarding the deleterious effects of the mentally retarded that closed the nineteenth century, became the social realities of the twentieth. The consequences of these changes affected treatment of the mentally retarded throughout Michigan, as they did in other states.

At first, administrators viewed the population positively. W. A. Polglase (1899), superintendent of the Lapeer institution, expressed this in explaining his

facility to members of the Board of Corrections and Charities said:

The purpose of the institution is not only to give care, but to educate them to use such methods and means as will produce in the child, as it grows, the greatest amount of usefulness. I believe that, taking all classes, we can make 25 percent self-supporting. (p. 87)

Three years later, Polglase in a report of the Board of Control for the Michigan Home, expressed a different view. In arguing for the establishment of a colony program, he stated that the able bodied feeble-minded and epileptic would find a permanent home where they could live in quiet happiness receiving the necessary supervision. If some deemed this system too expensive, they needed to consider other costs. He said:

The vastly greater expense to the state of permitting an irresponsible class of defects to infest the community, beget their own kind and add in a double ratio, their quota of crime and vice, as illustrated in the history of the celebrated Juke family of New York and the Ishmaelite family of Indiana. Until the cause of mental defectiveness has attracted more general attention and the importance of instituting means for its prevention is recognized, it would be but a better part of wisdom to provide means for their care in the most economical manner possible. (Michigan Home for the Feeble-minded and Epileptic, 1903, pp. 8-9)

In the next biennial Report of the Board of Control (Michigan Home for the Feeble-minded and Epileptic, 1904), Dr. Polglase notes that degeneracy and feeble-mindedness are caused by vice, over-work, ill health, poverty and ignorance of common laws of health and reason. Because

of this, action had to be taken to prevent feeble-mindedness. The first step was to secure permanent care for all imbeciles and defectives. He concluded, "An enlightened civilization demands this, not only for the sake of the mentally defective, but for the moral safety of society" (p. 14).

Polglase's philosophical changes from educating the mentally retarded for eventual return to society, to permanent care for the entire population, was not a matter of administrative expediency. Although he was building a case for expanding the institution, he appears to have shifted his views based on the commonly held opinions of the day. In Michigan, as in the rest of the nation, persons with mental retardation were viewed as a menace to the community and a drain on the moral fiber of society.

Such views were compounded by the reports of county charity agents who came into contact with the mentally retarded. For example, the agent from Montcalm County reported at a convention in late 1903 that he had received a complaint about a feeble-minded boy who had set fire to his own house. He could not send him to the Boys Reformatory because he was feeble-minded and the Home in Lapeer was full. The boy continually caused problems and finally was jailed. After he was released he set five fires in one evening and put stones on the

railroad track. He finally was sentenced by a court to the Institution for Criminal Insane at Ionia. The agent argued that the boy should be sent to Lapeer and held there for a long time because he would probably continue this behavior for the remainder of his life (Board of Corrections and Charities, 1904, p. 2).

More generalized indictments continued as well. Dr. Hal Wyman, a member of the Board of Charities, delivered a speech entitled, "The Relation of the Defective to the Community" in 1905. Wyman divided feeble-minded persons into two groups. He noted that the first class came very close to having no mind at all and that they did virtually nothing. The second class were individuals whose moral faculties were affected and from this group came the criminals. He stated, "If a little pain is taken to look over a criminal population ... you will find that a large percentage of those individuals are moral imbeciles" (Wyman, 1905, p. 31). Fortunately, Wyman continued, the State of Michigan was making a deliberate and careful effort to control the defective and their involvement with the community. He urged continued action so that the Lapeer institution could care for all from this defective group who were a "menace to our social institutions" (p. 33).

In 1913, the Board of Control of the Michigan Home submitted a request to the legislature to increase the

institution's capacity from 1,100 to 1,370. In requesting this \$181,000 special appropriation, they tied misconceptions of the mentally retarded to dollars. They wrote:

In asking the legislature for these requirements the Board have not been unmindful of the added burden of taxation which such an appropriation will entail, but believe the protection of society and the demands of the people for the care and class of persons should outweigh other considerations. (Michigan Home for the Feebleminded and Epileptic, 1913, p. 6)

During the first two decades of the twentieth century the view held of mentally retarded people reached its nadir. Significantly, this attitude was not fostered by the general public, but by administrators and professionals working with the retarded. While Michigan administrators were influenced by national trends and thought, at times they attempted to use negative issues to further their causes.

In an attempt to balance the picture, it should be noted that the work of institutions was not devoid of positive features during this period. As will be seen in the following section, programs for the population continued to expand and improve.

### The Programs

Each year during the twenty year period beginning in 1900, administrators of the Michigan Home for the

Feeble-Minded and Epileptic reported that their facilities were over-crowded. Waiting lists continued to grow. The state legislature responded by appropriating funds to construct new buildings and make general improvements. But the demand for additional space and programs continued.

Throughout this period, feeble-minded people continued to be admitted to poorhouses and jails, but fewer each year. A report by Sanderson (1909) notes, "A large, but rapidly decreasing number still remain in the county houses who would be cared for at Lapeer were the capacity of that institution equal to the demand made upon it" (p. 57).

Biennial reports give accounts of educational and occupational programs occurring at the institution. School work was directed toward the epileptic and those feeble-minded persons classified as imbeciles (higher functioning individuals). The Report of the Board of Control (Michigan Home for the Feeble Minded and Epileptic, 1906) states that training methods were calculated to develop the imperfect brain and body. The goal of education was to "fit the individual better to help themselves and contribute under judicious guidance to their support" (p. 13). To this end the report adds, "If selected cases were alone admitted, there is no question as to the possibility of making an institution

self-supporting" (p. 13).

Dr. G. L. Chamberlain (1908), second superintendent of the Michigan Home, remarked that about half of the patients were "employed" in different departments. These included the sewing room, laundry, dining room, housekeeping, farm, furniture shop and grounds department (p. 26). The Board of Control report (Michigan Home for the Feeble Minded and Epileptic, 1906) adds that other residents were assistants to nurses, lawn keepers, power house workers, plumber's assistants and construction workers (p. 14). The treasurer's report does not list any disbursements to residents. Therefore, it can be assumed that work was not paid and considered part of one's support.

Several reports reference the administrator's attempt to provide employee training. The 1906 report stated that some of the training problems included lack of staff and employee indifference. To remedy this, a plan of advancement and pay increases was coupled with completion of training programs.

From 1910 to 1912 the institution employed a "Eugenics worker." A common practice of the era, this person charted families to ascertain the extent of the defective population. Based on this work, in 1913 the superintendent determined that there were more feeble minded people in Michigan than first thought. He wrote,

"According to these figures we have only one-tenth of the defectives of Michigan in this institution" (Michigan Home for the Feeble Minded and Epileptic, 1913, p. 10).

The final program change that took place in this period was establishment of a separate facility for the epileptic population at Lapeer. For several years the Board of Charities and the superintendents of the Michigan Home had been advocating a separate facility for this group. In 1913 the legislature appropriated funds for the Michigan Farm Colony for Epileptics at Wahjamega. In 1914, 87 males were placed at the 1,500 acre farm near Caro, Michigan.

In summary, 1900-1920 was a period in which the institutional system continued to grow, yet remained unable to meet the demand for requested placements. Administrators and professionals in Michigan followed the national trend by emphasizing the menace and dangers of mentally retarded persons. Based on this, Michigan implemented a number of restrictive laws related to marriage and passed several eugenic related pieces of legislation.

The laws, portrayals of the population and programs developed within the institution during this period continued to impact upon the care and treatment of the retarded in Michigan for years to come.



### Continued Growth and Centralization (1920-1950)

Kanner (1964) referred to the years 1920 through 1950 as the "great lull" (p. 141). In Michigan it was a time of continued growth and consolidation of the expanding care system. It was also a time when the system often failed to meet requests for services. Legislation attempted to respond to increased needs for care, while stressing the necessity of economy and efficiency. Yet, continued population growth created long waiting lists for services and forced institutions to develop programs beyond the hospital. During this period, social service departments, outpatient clinics, parole and employment programs were developed. The eugenics scare, which began in the early 1900s, would eventually fade away, reducing demands for segregation and sterilization.

The initial formation of a centralized state system for the care and treatment of mentally retarded people took place during this 30 year period, created by revisions and amendments of state laws written during the last decades. In his first address to the Legislature, Governor Chase Osborn ridiculed the numerous state boards. He said, "It is true the State has as yet no trustees of wash basins or toothbrushes, but if we keep on going there will be nothing from fish eyes to fox

tails that will not be supervised by a board" (Fuller, 1927b, p. 593).

Other leaders criticized the trustee form of governance, even within the state institutional system. As the following section will show, it would take a number of years to consolidate the independent facility programs.

### The Law

In the early 1920s, the state bureaucracy began to develop more rapidly than ever before. As a response to the many boards and independent sets of trustees, the legislature created the State Welfare Department. Public Act 163 of 1921 provided for the management and control of state hospitals, prisons and other specialized institutions. It also abolished the boards which governed various institutions, replacing them with consolidated commissions. The State Board of Corrections and Charities which had been influential in the development of services for the mentally retarded--and had provided a forum for debate of treatment concepts--was also abolished by this act (Public Act 163, 1921, p. 335).

Section 7 of Public Act 163 of 1921 created the State Institute Commission within the State Welfare Department, which replaced the boards of trustees at the

Michigan Home and Training School, the State Public School and the schools for the deaf and blind. Interestingly, jurisdiction for the Michigan Farm Colony for Epileptics was placed under a separate commission, the State Hospital Commission which was also to oversee the five hospitals for the insane (Public Act 163, p. 337). Such an operational division highlights the continued confusion regarding definitions of feeble-minded, epileptic and insane populations in Michigan.

Public Act 163 provided that institution superintendents would be appointed by the Governor and serve at his pleasure. When a vacancy occurred, the Governor would select a superintendent from a list of names presented by the Commission. Facility appropriations continued to be on an individual basis and were not channeled through the State Welfare Department.

Very specific restrictions regarding visitation and inspection were established for the Department and the State Hospital Commission by Section 11 of the Act. Visits were to gather information and make recommendations for better protection of patients. However, these provisions appear to have included only the five state hospitals and the Farm Colony, and not to the Michigan Home.

One other interesting section was written into this legislation related to residents of the Michigan Home,

the Farm Colony and the State Public School. Section 13 allowed for the superintendent to place a person with a family for employment. The section defines the criteria for the resident as: "Any person committed thereto is competent mentally and capable physically of performing useful labor for hire without such institution, but has not yet regained a normal mental or physical state." The person was then placed in the care and custody of the head of a household on a temporary basis. The person was still legally committed to the institution, which was liable for medical care, but the individual lived in the community with a family (Public Act 163, p. 341). This practice, in some respects, foreshadowed the establishment of foster care homes.

The significance of this section of Public Act 163 of 1921 was that it recognized that some people were capable of leaving the institution.

The second law which assisted the development of a state-wide system of care was Public Act 151 of 1923.

The introduction states:

An act to revise and consolidate the laws organizing hospitals for the insane, homes and schools for the feeble-minded and epileptic, institutions for the discovery and treatment of mental disorders; to regulate and provide for the care, management and use thereof; to provide for the licensing, visitation and supervision of privately owned hospitals, homes and institutions for the care and treatment of such mentally defective persons; to provide for the apprehension of persons believed to be insane, feeble-minded, mentally defective or

epileptic, and their commitment, to provide for their care, custody, parole and discharge, to provide penalties and to repeal certain acts or parts of acts contrary to the provisions hereof. (Public Act 151, 1923, p. 218).

This Act moved jurisdiction and control of the Michigan Home from the State Institute Commission to the State Hospital Commission. The Hospital Commission, under the auspices of the State Welfare Director, was responsible for (a) direction and control of property, (b) recommendation of superintendents, (c) determining officer's salaries, (d) inspection of facilities and (e) annual reports to the governor. The commission was also given the power to inspect private hospitals.

Although the commission was given these statutory responsibilities, it was not given authority to hire staff to carry them out. The Michigan Department of Mental Health (1962a) written history states:

In actual practice the Commission functioned as an advisory board, and its activities consisted, for the most part, in holding an average of one meeting per month at one of the state hospitals where the members of the Commission conferred with the medical superintendent. (p. 13)

Minutes of the commission meetings support this viewpoint. Members consistently reviewed reports from superintendents, approved lists of new hires and discussed facility needs. For example, the minutes of the December 12, 1924 meeting show that beyond the standard reports only two items were discussed--the

condition of the herd at the State Home and installation of a new water pipe to the superintendent's house (State Hospital Commission, December 12, 1924, p. 3). The minutes reveal very little input from anyone other than commissioners and superintendents. In general resolutions were based on recommendations by superintendents, which were moved and carried by vote of the commission.

Waiting lists continued to grow for admission to all state institutions, leading to the passage in 1929 of the Hartman Act (Public Act 324). This was a landmark piece of legislation that appropriated over \$27 million for the construction, repair and remodeling of numerous state mental, educational, correctional, and military institutions. The Michigan Farm Colony was allocated \$1.4 million and the Michigan Home \$2.2 million for construction of new facilities between 1930 and 1933.

Governor Fred Green reluctantly signed the legislation stating that it put a huge tax burden on the state, but for a laudable purpose. He added:

I must accept it or neglect the protection of society and let the thousands of unfortunates who are now being cared for in our over-crowded asylums, in jails, county houses, or not begin cared for at all, continue to suffer. (State of Michigan Public Act 324, 1929, p. 913)

Unfortunately, the Great Depression began shortly after the Hartman Act was passed and in 1931 the

appropriation was extended to a ten year period. In his January, 1933 address the outgoing Governor Wilber Brucker referred to this action and urged the legislature to continue the program of construction in order "to keep faith with the taxpayer and at the same time make substantial progress toward alleviating the suffering of these unfortunates" (Brucker, 1933, p. 14). That same year the Hartman Act was repealed, stopping all construction. A special session of the legislature in November, 1933 made it possible for Michigan to participate in federal programs which assisted with facility repair and construction during the years prior to World War II (Kebler, 1963, p. 4).

In 1936 Frank Murphy was elected Governor of Michigan on a New Deal platform. In his first address to the legislature, Murphy (1937) proposed reforming the state's welfare system, which included three state facilities for the feeble-minded and the Farm Colony for Epileptics. He said, "Economy, efficiency, and harmony require a reorganization of the present system of dealing with these matters. Many of the state commissions and offices should be abolished, and a new centralized, modernized state system created" (p. 9).

Murphy proposed creating a Mental Hygiene Department to supervise all state hospitals and institutions for the insane, epileptic and feeble-minded. The legislature

responded with Public Act 104 of 1937, which made the State Hospital Commission a separate entity from the State Welfare Department. The Act provided for hiring a Director of State Hospitals and other staff, as needed (p. 150). The established duties of the commission and staff did not vary greatly from those delineated in the 1923 law.

One change was that superintendents of institutions were to be appointed by the commission and not by the Governor (p. 151). This change was indicative of the growth of the state bureaucracy and the size of mental health programs, even compared to 15 years earlier.

Also included in Act 104 of 1937 was clarification of patient employment. Section 5, paragraph 7 states that the superintendents were responsible for providing employment to all patients who would be benefited by regular labor. In addition the clause said, "No payment shall be made or credit given on account of any labor done by any patient while an inmate of such institution" (p. 153). This was the first time the law specifically stated that no pay would be provided for either outside or parole employment, since people were inmates of the institution regardless of job placement.

Finally, a clause related to research and prevention showed the expanding concepts of care and treatment in the state. Section 4, paragraph 15 directs the



commission to:

Undertake and promote studies of the causes, nature, and the methods of care, treatment, and prevention of insanity, feeble-mindedness, and epilepsy; and develop and conduct a statewide mental hygiene program, with emphasis upon the promotion of mental health and the prevention of insanity, feeble-mindedness, and epilepsy. (Public Act 104, 1937, p. 152)

Changes in the system continued when in 1939 the legislature abolished the position of Director of State Hospitals and replaced it with the positions of Executive Secretary and Director of Mental Hygiene. The Director was to be a physician with at least five years experience in the treatment of mental diseases. The statute adds that his function was to "carry on the mental hygiene work authorized under this act" (Public Act 214, 1939, p. 406). No further definition of functions were given, nor were funds appropriated to pay the Director's salary.

Michigan Department of Mental Health (1962d) records indicate that between 1939 and 1942 the central office of the State Hospital Commission consisted of an executive secretary and clerical assistance. It was not until 1941 that the legislature allocated funds for a Mental Hygiene Director. The position being filled in March, 1942 (p. 16). The initial role of Mental Hygiene director was "to expand the scope of mental health services in Michigan" (Kebler, 1963, p. 4). His function was to: establish and supervise child guidance clinics, establish and

supervise family care programs and expand hospital outpatient clinics (Kebler, 1963, p. 4). Each of these roles were designed to take programs and services into communities, as part of the state's hospital system.

On January 4, 1945, Governor Harry Kelly proposed to the legislature that an administrative reorganization of the State Hospital Commission was in order. He noted that 25,000 people were residents in state institutions and the overall mental health budget was \$15 million per year. He said:

I therefore believe that the time is at hand to vest sole responsibility for administration of the mental health program in one directing head and to reorganize the Hospital Commission as an advisory group to that Director. I believe that such action will permit greater mobility in operation, more economy and more efficiency, and I submit this for your consideration. (Kelly, 1945, p. 27)

Five months later Public Act 271 of 1945 was approved. The Department of Mental Health was created and the State Hospital Commission abolished. As the Governor requested, the position of Director of Mental Health was established. Qualifications for the position required that the person be a psychiatrist with at least 10 years experience in treating mental diseases (Public Act 271, 1945, p. 427). It should be noted that this provision would ultimately impact upon the mentally retarded because it mandated that the director be experienced in treating mental diseases, not retardation,

thus producing a department oriented toward mental illness and not mental retardation.

The legislature did not concur with the Governor about creating a Mental Health Commission simply as an advisory body to the Director. Public Act 271 of 1945 provided that the commission and the Governor appoint the director. The commission was authorized to lease lands and carry out the provisions of the Act. Policies and regulations were to be established by the commission and director (Public Act 271, 1945, p. 426). The five member Mental Health Commission played an important role in the operations of the department until 1963.

The laws from 1920 until 1950 concentrated on the development of a system to care for the growing disabled population of the State of Michigan. From 1921 until 1937 the State Hospital Commission was a division of the Welfare Department. As hospitals and institutions grew larger, the Hospital Commission was separated from the Welfare Department, and from 1937 to 1945 operated state institutions for the insane, feeble-minded and epileptic. Beginning in 1945 the Department of Mental Health was designated to operate hospitals as well as provide a broader spectrum of services in the whole area of mental hygiene. Each phase in the development of this comprehensive system resulted as both the population and programs grew larger and larger.

### The Population

Only limited information exists about the people classified as mentally retarded between 1920 and 1950. With the abolition of the State Board of Corrections and Charities in 1921, one of the major forums for presenting new developments in the field was lost. The types of information collected by the welfare county agents changed, and publication of convention proceedings ended in 1920.

During this period Michigan appears to have followed the national trend in collecting standardized form of information on the mentally retarded. Lakin (1979) found that from 1926 on, the only information required by the census bureau related to ages, sex and level of retardation of mentally retarded persons committed to the nation's institutions (p. 41).

The annual reports from facility superintendents during this thirty year period also became much more quantitative. They reported on the age and sex of inmates routinely and occasionally on national origin and place of birth. Information was also kept on the size of the facility waiting list and the numbers of residents on parolee, visits or escape status. Interestingly, the annual reports of the facilities from the mid-1940s eliminated discussions of residents altogether. They

focus on the "business of the institution," that is, farm operations. These reports detail the costs of operation and record the value of the products and livestock produced (Michigan Home and Training School, 1945-1949).

The State of Michigan Archivist has suggested that some information may have been lost during this period due to two events. First, during World War II there was a paper shortage that prompted drives to collect scrap material. Trucks were filled with documents and records stored in the State office building that those in charge considered of no value. Second, in 1952 a fire destroyed the office building which housed the state library and archives.

What is known is that the identified population of mentally retarded people continued to grow. The State Hospital Commission (1939) produced a statistical report of resident movement in each of the institutions for the mentally defective and the hospital for the epileptic. Statisticians found that between 1915 and 1938 the resident population in institutions quadrupled, while the population of the state showed a fifty per cent increase. Facilities for housing people increased by two and one-half times during the period (p. 56).

In 1920 there were 1562 mentally retarded people and 428 epileptic people in state facilities. In 1938 the numbers were 4849 and 699 respectively (State Hospital

Commission, 1939, pp. 58, 82). Department of Mental Health monthly population reports show that by 1950 the number of residents had risen to 7472 mentally retarded and 1487 epileptic persons (Department of Mental Health, 1922-1955). In this thirty year period the total population in facilities had increased from 1,990 to 8,959.

The State Hospital Commission Statistical Report (1939) collected other information that provided some indication of the types of people in institutions during the period. Between 1935 and 1938 only 25 percent of those admitted to facilities were classified as idiots or imbeciles. The remaining 75 percent were classified as moron, borderline or dull normal (p. 70). The report does not indicate which classification system was used, but the significance was that a majority of the residents were relatively capable people.

As a point of reference, a committee of the American Association on Mental Deficiency defined idiots as those who have a mental development not exceeding that of a two year old, imbeciles as those not exceeding that of a seven year old and morons as those that do exceed the mental development of a 12 year old (Committee on Classification of Feeble-minded, 1910, p. 61). Others stated that imbeciles could perform tasks of duration, like washing dishes; morons could use machinery and tend

animals (Scheerenberger, 1983, p. 182).

Such definitions and classifications also explain why high numbers of residents were able to be employed at the institutions. For example, in 1935 of the 3686 residents at the Michigan Home and Training School, 3198 (87 percent) were employed (Department of Mental Health, Monthly Population Reports, 1922-1955).

One other piece of information from the commission report provides insight about the population of Michigan's facilities. In 1938 the average age of the persons committed was 23.96 years at institutions for the mentally retarded and 32.4 years at Caro Center for the Epileptic. Most residents were between 15 and 19 years old, comprising slightly more than 25 percent of the total. Had the original age limits (6-21) still been in effect, the population of Michigan's institutions would have been approximately 3,400 instead of 6,597 in 1938 (Monthly Population Reports - 1922 to 1955, pp. 69, 87).

The population in need continued to grow and place demands on Michigan institutions. The State Hospital Commission (1939) report indicates that annually between 1915 and 1938 facilities for the mentally retarded were, on the average, 42 percent over their capacity. In 1935 they reached a high of 59.6 percent over capacity. During the same year, waiting lists reached a high of slightly over 2000.

As the population grew in size, so did awareness of the problem of mental retardation. It was during this period that Michigan re-enacted its sterilization laws, as previously discussed in this chapter. Act 281 of 1929 was clearly eugenic. The title said it was, "An act to prevent the procreation of feeble-minded, insane and epileptic persons" (p. 689). Shartel (1925) noted that the problems of 1913 could be avoided by including all feeble-minded people in the revised act. He also described the reason why such legislation was important: "A feeble-minded person is a mental dwarf ... sometimes because his ancestors were also under-developed mentally, sometimes because of disease; but always he is a person with subnormal mentality" (p. 3).

Another view of the population was provided in a 1936 Detroit News interview with Fred Woodworth, state welfare director. He stated that sterilization of the "unfit" had become a social benefit in Michigan. He added, "For an operation that costs about \$30, the State has protected itself from a potential menace" ("Sterilization Law Praised," 1936, p. A1). The Michigan Home and Training School, at the time the largest institution of its kind in the world, had performed over 900 sterilizations. Many according to Woodworth, were voluntary.

The "voluntary" nature of this consent is better



understood by reviewing institution records of the day. In a letter to Woodworth, R. L. Dixon (1935), medical director of the Home and Training School described one situation. He said, "The matter of sterilization has been discussed with both girls and they seem willing that it be performed, with the understanding that they would be placed at work outside the Institution upon recovery" (p. 1). In other words, if one wanted to get out, they consented to the operation.

Davies (1959) found that a total of 2,864 sterilizations were performed in Michigan between 1929 and 1958 in state hospitals (p.54). No records were kept on how many were performed by family doctors.

Between 1930 and 1950 the population seemed to become more publicly visible and requests increased for placement into state institutions. Not only did the institutions grow, but so did the programs within them. The following section highlights some of these changes.

### The Programs

Programs of this period were an expansion of what had occurred earlier. They were developed to address the growing numbers of people requesting institutional placement. One of the first was a county, rather than state, program. In 1922, the voters of Wayne County approved establishment of the Wayne County Training

School for High Grade Mentally Defective Children. The school was located near Northville, Michigan, and opened in 1925 (Fuller, 1939, p. 366).

County authorities administering this program only admitted the "highest level" mentally retarded people. The program was oriented toward practical training and socialization, with a high degree of supervision (Fuller, 1939, p. 367).

As a means of expanding facilities to meet the need, administrators proposed in 1934 that an arm of the Lapeer State Home and Training School be opened in Mt. Pleasant. The new institution was established in buildings formerly occupied by the United States Indian School, which had been given to the state by the federal government. For three years this facility operated as a boys vocational unit and took trainable (higher functioning, more capable) males under the age of 30 as its residents (Department of Mental Health, 1962, p. 15).

Three years later in 1937, the facility became the Mt. Pleasant State Home and Training School independent of the Lapeer program. Michigan Public Act Act 104 of 1937 designated the institution as a "hospital, home and training school for the humane, scientific, and economical treatment of feeble-minded persons" (p. 149).

Governor Frank Fitzgerald (1935) noted that the concept of a state orphanage was obsolete and suggested

changing the State Public School at Coldwater into a facility operated by the Hospital Commission (pp. 11-12). On October 1 of that year the Michigan Children's Village was opened accepting mildly retarded children who were capable of academic education or vocational training (Coldwater Regional Center for Developmental Disabilities, 1981, p. 2).

Even with additional space, other problems continued to plague the system. In a letter to James Milliken of the Hospital Commission, from Mrs. Oscar McEwan (1937) conditions at the Lapeer facility are outlined. Mrs. McEwan was the mother of one of 50 boys housed in a cottage at the institution. She stated that all of the boys spent the entire day bare footed, seated on wooden benches in a basement area. She added, "I was told a year ago that those low grade boys had to be out of sight as they might be soiled and their living room could not always be in order and the visitors might not like it. That's a lot of nonsense--the inmates come first" (p. 2).

The State Hospital Commission evidently got other complaints about care and treatment of residents in public facilities. In 1938 the Director of the Coldwater facility was asked why residents spent most of their day, including meal times, laying on the floor. Dr. J. E. Barrett's (1938) response offers insight into the professional view of the population. He wrote, in part:

I am told many of the crippled children prefer to be on the floor. They are so crippled and deformed that it is impossible to set them up at a table so it is said to be necessary for them to take their meals while lying on the floor, but at all times an attendant is assisting them with their feeding, or some of the better patients are" (p. 1).

Examples also exist of praise for institution staff. Dr. Barrett's approach is less evidence of a totally inadequate system of care than the stresses of overcrowded conditions and staff shortages. At this point, Michigan's care system was strained to its limits.

Governor Van Wagoner (1941) in a message to the legislature, stated that not all of the available space could be used, because there was no equipment. He concurred with the request of the State Hospital Commission for appropriations adequate to operate state hospitals (p. 9). Governor Kelly (1943) in his message to the legislature two years later proposed that a fund of two million dollars per year be put aside to develop state hospitals after the war emergency had ended (p. 11).

Kelly (1945) in his next report to the legislature detailed the measures that had been taken to reduce waiting lists. He wrote:

During this past year many different possibilities have been examined to find a solution for those patients needing hospitalization. At the Lapeer State Home and Training School, 200 additional beds have been made available by the remodeling of two old abandoned buildings, and 50 beds have been added by further overcrowding existing facilities. At the

Mt. Pleasant State Home and Training School, 40 beds have been added by remodeling. Two hundred fourteen beds have been added at the Coldwater State Home and Training School by overcrowding existing structures, and 24 more beds will soon be available as a result of repairs and alterations. All these changes have not been especially desirable but are warranted under the emergency, and a total of 578 additional beds have been made available for feeble-minded patients by that process. (p. 57)

In the same report Kelly (1945) added that overcrowded facilities were not the only problems in the institutions. He noted that acute shortages in staff had led to lower morale and very long work hours. The entire system, which required 4,800 employees, had operated with an average of 1,300 vacancies throughout the year (p. 58).

As this period neared an end Governor Kelly (1946) summarized Michigan's mental retardation services. He wrote, "In the minds of many persons the mental health problem constitutes merely a matter of institutionalization behind locked doors. Fortunately Michigan has in recent years gone beyond such a narrow and obsolete concept" (p. 55). He discussed specifically the opening of child guidance clinics and the establishment of family care programs. Unfortunately, neither of these programs impacted upon the care and treatment of the mentally retarded immediately. Both were initially aimed at the mentally ill, but sufficed to establish a concept of service beyond the institution in

**Michigan.**

The period from 1920 to 1950 was one of continued institutional growth in Michigan. This was the time Wolfensberger (1975) referred to as "momentum without rationales" in his history of national institution development (p. 55). As has been shown, rationales were not totally absent in Michigan, but they had clearly changed from earlier periods. During the first portion of the twentieth century, the concept of institutions for the care and treatment of the mentally retarded had become accepted. This meant that the value and purpose of institutions no longer had to be debated.

The rationale for the institution was to perform its function. Appropriation arguments to the legislature by hospital administrators became the same year after year, that is, to provide more facilities in which to place the feeble-minded and epileptic who could not be served at home or in the community. The existence functions of institutions were no longer challenged.

By the 1890s professionals had successfully argued the need for institutions and were gradually shifting their purpose from habilitation to maintenance. In addition, the Great Depression of the 1930s diverted social service budgets and development in the state, causing more families to request placement in institutions and making it more acceptable to overcrowd

facilities beyond designated capacities, even when they were severely under-staffed. World War II also took attention away from the needs of the retarded, thus allowing the system to continue to grow virtually unchecked until the 1950s.

#### Preparation for Change (1950-1960)

The 1950s would prepare the State of Michigan for significant changes in the methods of providing residential care to mentally retarded people. The state as a whole would undergo large changes during this period. The period began with the Michigan Joint Legislative Committee on the Reorganization of State Government (1951) finalizing its report. After two years of study and 29 separate reports, the committee called for sweeping reforms in the system of councils, commissions and agencies that had become part of the Michigan governmental bureaucracy (pp. 1-25). The decade would end with intense discussion regarding re-writing the state's Constitution, ultimately reshaping the governmental system of the state. During this period a single governor served the state, G. Mennen Williams. It was in this political atmosphere that changes related to the residential care and treatment of retarded people would take place.

### The Laws

The first act of this period to impact the mentally retarded was an amendment to earlier legislation forming the Department of Mental Health. The significance of Public Act 148 of 1952 was to keep Michigan current with popular concepts of mental retardation. The legislation substituted the words "mentally handicapped" for feeble-minded when referring to idiots, imbeciles and morons. The definition also made a distinction in Michigan law between the mentally ill and mentally handicapped for the first time.

Three other laws began to clarify public responsibility for the education and training of mentally handicapped children in the state. These were significant because, it was argued, if mentally retarded children were in school or had activities during the day, the need for institutionalization would decrease.

Public Act 188 of 1956 appropriated \$50,000 to reimburse school districts which provided special education classes to mentally handicapped children under 16 years of age. (Public Act 195 of 1958 increased the age limit to 21 years.) The Act stated that the programs had to meet established standards and could not exceed one-half the per capita amount allotted per elementary child in the school district.



In implementing this legislation, the State Department of Public Instruction included three programs. Type A programs were for pupils who were mentally handicapped but potentially socially competent. Type B were special classes where the pupil was separated from other pupils on a trial basis. Type C classes allowed the child to remain in regular classes with special consultation given to the teacher.

Type B programs created a controversy because some administrators and teachers felt that it was not the school's function to teach children in the lower, trainable range of mental retardation. Some school districts evidently used this class as a diagnostic procedure, after which the child was placed in either Type A or C programs. Pupils that could not be placed were excluded from school (Andrew, 1959, pp. 10-12).

The third education oriented piece of legislation was Public Act 148 of 1957, which allowed establishment of county day school programs for epileptic and mentally handicapped children. This law specifically addressed those children who could not be educated in regular school programs. This legislation will be discussed in the program section, which follows.

Public Act 182 of 1959 strengthened the licensure laws for homes caring for mentally ill, mentally handicapped and epileptic people. This legislation set

the foundation for community placement programs, which would grow rapidly in the 1960s and 1970s.

In 1955, one other legislative event impacted on the care of mentally retarded people. That year the governor called two extra sessions of the legislature to complete unfinished business. The sessions created an intense battle and also served to bring the issue of care for the mentally retarded before the public. Governor Williams (1961) later wrote:

The special session of 1955 for example, included among other subjects, a strict numerical speed law and a program to relieve the intolerable overcrowding of our facilities for retarded children. The case for the latter seemed so just and so appealing that I spent relatively little time on the subject, whereas the resistance to a specific speed law was so entrenched and vocal that I really went to work on that matter. When the session got underway, I was surprised to have the speed law go through with relative ease and see the fight for retarded children turn into a bitter controversy which required another special session and an all-out public battle. (p. 3)

These extra legislative sessions were the culmination of many years of effort to reduce waiting lists at institutions. In 1947, Williams predecessor, Governor Kim Sigler, had proposed a \$60 million bond issue to construct new mental health facilities. In making, his proposal Sigler noted that additional money was only part of the problem. He added that there must also be an "enlightened public interest and awareness of needs" (Department of Mental Health, 1947, p. 1).

In 1950 the Department of Mental Health prepared a report entitled A General Plan for Expanding Michigan's Mental Hospital Facilities. It proposed adding 2,880 new beds for mentally deficient people by 1960. The plan called for a new 2,500 bed institution and additions to reduce over-crowding at existing facilities. It also proposed establishing 156 additional family care beds in the state (p. 13). An internal Department of Mental Health analysis of the plan five years later (dated September 22, 1955) found that funds had been authorized to add 1202 beds, but no new facilities were authorized (p. 1).

Waiting lists continued to grow, while pressure continued to build in the system. Probate judges began to speak out on the issue. For example, Judge Arthur E. Moore (1955) wrote Governor Williams to ask, "When is something going to be done? It has been my experience that this deplorable situation has existed continuously since 1938" (p. 2).

Between July and September, 1955, the Detroit Free Press published 24 articles about the condition of Michigan's institutions. The majority of these were written by a columnist named Warren H. Stromberg. He wrote of deplorable conditions and inhumane treatment in state institutions. They also told of the problems faced by families with children on waiting lists.

Mid session, 1955, Senate Bill 1387 and House Bill 350 were introduced in an attempt to respond to the need for additional institutional space. They proposed the transfer of the Howell tuberculosis sanatorium from the Health Department to the Department of Mental Health since the sanatorium was no longer fully utilized. Many County Boards of Supervisors supported the measure, as did the State Controller. A group called the Citizen's Research Council of Michigan also backed the proposal because they found that 37 percent of the beds in four state sanatoriums remained unused. Dr. Hugh Robbins, Director of the Health Department, was opposed to the legislation. His feeling was that the Department of Mental Health had money of its own for hospitals, and Health Department funds should not be substituted. The bills did not pass either house chamber (Department of Mental Health, 1955c,).

In October, 1955, the Department of Mental Health submitted to the governor A Program for the Emergency Hospitalization of Mentally Retarded Children. This document assessed the waiting lists and overcrowded conditions of Michigan's institutions. Over 1200 people were waiting for placement. The report stated that before 1961 over \$70 million would be needed to meet Michigan's needs. A four year program to develop 5,900 new beds (4,600 for new space and 1,300 for the

replacement of obsolete facilities and relief of overcrowding) in addition to the 8,300 existing beds was proposed.

The legislature decided to take no action on additional facilities during the regular session, so an extraordinary session was called on November 1, 1955. In his message to the legislature for this session, Williams (1955a) stated that waiting lists for mental retardation facilities were increasing at the rate of 31 people per month and that 66 percent of those waiting needed either nursery or custodial care. He requested the following appropriation:

1. \$47,000 to expand the family care program.
2. \$60,000 to contract for existing hospital beds.
3. \$1.6 million to purchase the Farmington Children's Hospital.
4. \$350,000 to convert an Army hospital facility at Fort Custer, Michigan, to a temporary facility.
5. Funds to expand the Coldwater and Mt. Pleasant institutions by 350 beds.

Williams added that these were emergency requests and that a long-range and permanent program would be presented at the next regular session (p. 10). The bill, introduced in the Senate, contained all of the elements requested by the Department and Williams except the

purchase of the Farmington Children's Hospital. It passed the Senate on the second day of the session by a vote of 32 to 0 and was given immediate effect (Senate Journal, 1955a, p. 40).

The legislation was sent to the House of Representatives which added amendments to purchase the Farmington facility and the Oakland County Tuberculosis Sanatorium. This increased the cost of the bill from \$1.1 million to \$5.02 million. The Senate voted on a motion to concur with the amendments, but the bill was defeated 22 to 10 (Senate Journal, 1955a, p. 65). The legislation was referred to conference committee two times. Each time the committee could not agree; the House insisted on its amendments while the Senate refused to purchase the additional facilities.

A House amendment was offered to strike the purchase of the Farmington facility in an attempt to compromise. It was defeated. House members felt strongly that the beds available at the Farmington hospital were necessary (Journal of the House of Representatives, 1955a, p. 48).

Coming to no resolution, the Senate read the following statement into the Senate Journal, (1955a) and adjourned the special session:

We deeply regret the inability of the Conference Committees to agree on a Mental Health bill. The position, taken by the Senate, in passing Senate Bill 1020 met the emergency needs, as outlined in the Governor's message. The House insisted on the

purchase of the Childrens' Home at Farmington, or nothing. We are opposed to the purchase of any property, which might jeopardize the location or prejudice the decision, for the location of a new permanent institution for retarded children in Southeastern Michigan, for which a survey is now being made. Our program is sound, it does meet the emergency needs of the State, and the Senate has no reason to be ashamed of it. (p. 80)

The Republican controlled Senate could not agree with the Democratic House, their chief concern being the impact of the purchase on the selection of a site for a facility in the greater Detroit area.

Not satisfied with the results, Governor Williams called a second extraordinary session to begin the following week. On November 7, 1955 he addressed a joint meeting of the legislature. He apologized for calling the second session, but told the legislators that it was on behalf of 1250 mentally retarded children and their families. He said, "It is true, there has been some bitter feeling on both sides. ...This has been a division only as to methods of solving our problem" (Williams, 1955b, p. 7). He continued by reminding members that public service to the disabled was not a partisan issue. He added:

If we do even one iota less than enough, we will consign one or more of these retarded children and their families to continued darkness and despair. As guardians of the public conscience and creatures of a loving God, we simply cannot permit even one such child or one such family to be without the very best that we can provide under these difficult circumstances.

We are not dealing with social theories or dollars and cents in this matter. We are dealing with human beings created and loved by the same God who created and loves us.

And, believe me, ladies and gentlemen, these children and their parents need our help. (p. 8)

Williams then recommended adoption of the House plan, purchasing the properties in Farmington and Oakland County. He assured the legislature that purchase would not preclude development of a long-range plan to build additional facilities (p. 10).

The second session was even more heated than the first, continuing until December 14, 1955. Compromise after compromise was attempted, some of them including innovative ideas. The Senate proposed providing "field training of the mentally retarded in their communities" so that they would not need institutions (Senate Journal, 1955b, p. 16). A proposal was also made to appropriate \$100,000 to develop preliminary plans for a 2,500 bed institution in southeastern Michigan as a guarantee it would be built (p. 24). The Senate also suggested increasing the number of Family Care (community) beds from 100 to 300. The Department of Mental Health said it could not find that many suitable homes (p. 43).

After 15 votes in the Senate and 16 in the House, Public Act 1 of the Second Extra Session was passed (Journal of the House of Representatives, 1955b, pp. 86-89). When considered in conjunction with previous



appropriations, this bill authorized development of 5803 new institution beds for the care of people who are mentally retarded in the State of Michigan between 1956 and 1959.

The laws of the 1950s paved the way for changes to occur in coming decades. Ideas such as training in the community, release of people from institutions and the consideration of the impracticality of placing every mentally handicapped person in a facility, were in their embryonic state. What would force these, and other ideas, to develop was the continued population growth. Upon his retirement Williams (1961) said, "In 1955 we met a bed overcrowding crisis in this area, but the bed shortage is again assuming crisis proportions" (p. 36).

#### The Population

The most obvious factor about the population during the 1950s was that it grew much faster than the State could serve it. The need for additional hospital beds continued because of the increasing number of people committed to institutions by the probate courts. A Michigan Department of Mental Health (1955b) report entitled A Program for the Emergency Hospitalization of Mentally Retarded Children describes this problem. "The number of new cases being committed by our probate courts and appearing on our waiting list each month continues at

a high rate without abatement" (Department of Mental Health, 1955b, p. 5).

The Department classified individuals on its waiting lists into four categories: Nursery, custodial, school and trainable. The nursery group was comprised of very young children, starting at a few weeks of age. The custodial group were more severely retarded and were the people assessed as having no ability to learn anything. At the time of the Department's report (1955) these two dependent groups accounted for 86 percent of the waiting list (p. 5).

In an internal Department memorandum from a procedures analyst named Henry Glass to Charles Wagg, Department of Mental Health Director, it was revealed that a two year wait for placement was not uncommon, after a child had been committed by the court. Glass (1955) wrote, "The analysis indicates our inability with existing facilities to do other than pick off the most urgent cases" (p. 1). Lee Trumble (1986), a parent whose child was one of those on a waiting list confirmed the problem. "Admissions became a political thing. If you knew the right people you could get your child in, if not you just suffered."

During the debate on the appropriation bills for expanded facilities, Senator Cora Brown a member of the legislature's Mental Health Interim Study Committee,

pointed out that the problem was larger than the 1250 retarded children on the waiting list. In public hearings the group heard from parents of retarded children, employee organizations associated with mental institutions, school personnel and probate judges.

Brown (1955) explained that annually a parent had to repetition the court to keep their child on the waiting list. If they did not use this process the child's name was deleted. Brown had been told by various probate judges that families found the process cumbersome and often hopeless. She said:

It is their opinion that one-half to two-thirds more retarded children are in the community who have been committed but whose names do not appear on the waiting list because their parents become discouraged and allow the commitment to become inactive. (p. 26)

The number actually desiring placement in 1955 may have exceeded 3,000.

By the mid-1950s children of the baby boom era were reaching the age at which mentally retarded people were most likely to be hospitalized, that is, between 6 and 12 years. The Department of Mental Health emergency report (1955b) noted that the increased number of children requiring institution placement was an outgrowth of the state's expanding population. It stated, "If one notes the rapid growth in the number of births in Michigan commencing in the late 1940s, we find the basis for these

expanding waiting lists (p. 6).

Despite waiting lists and funding problems, the number of individuals in facilities continued to increase. In 1950, state institutions for the mentally retarded housed 8959 people. At the end of the decade, the population had grown to over 11,000 in seven facilities (DeLoach, personal communication, 1986).

Warren Stromberg (1955a) reported on conditions at Lapeer State Home. He observed that the facility was overcrowded and beds so close together that there was no room to walk between them. Even the most severely disabled individuals were not admitted because there was no space (p. 8A).

Reports of abuse toward residents increased, too. In 1958, for example, the Detroit News wrote about alleged abuse of State Representative Carroll Newton's brother-in-law. An investigation was launched because Newton's brother-in-law had a broken jaw and bruises. The Department of Mental Health claimed that the young man had received the injuries from another resident and not a staff person (Abuse at Coldwater, 1958, p. 1).

By the late 1950s institutions were no longer isolated from public view, the sole domain of a medical superintendent. They had become a visible, state-wide problem. Unfortunately, so had the retarded, as they were once again portrayed as dangerous to the community.

in 1955 a front page headline in the Detroit Free Press read, "1500 Retarded Wait." The sub-head read, "They Could Kill or Attack." The article estimated that one-third of the retarded could be aggressive. The administrator at Coldwater State was quoted as saying, "If the retarded person is put in a series of situations that antagonize him, he may commit a homicidal act--if he is not under supervision" (Stromberg, 1955b, p. A1).

It must be remembered that these effected a comparatively small number of mentally retarded people in Michigan were institutionalized. The majority were at home and in the community with families and relatives. Many of these families would become influential in developing emerging concepts of retarded individual's needs.

In the late 1940s parents with children in state institutions began to form groups to achieve common goals, such as visiting rights and adequate basic care for their children. Small groups developed in various parts of the state and in June, 1951, the Michigan Association of Parents and Friends of Mentally Retarded Children was organized. By October of that year representatives of the group had met jointly with Mental Health Director Wagg and Governor G. Mennen Williams. A letter from H. J. McKercher (1951), president, to Williams asked the governor to address the needs of

mentally retarded children both in institutions and at home. By 1959, Andrew found that the group had grown to 50 local units with more than 4,500 members (p. 14).

The group, shortening its name to the Michigan Association of Mentally Retarded Children (later Association of Retarded Citizens), became politically active. Annual legislative conferences were held, in conjunction with groups such as the Michigan Welfare Conference. The November 13, 1956 conference had two sessions on community life for the mentally retarded entitled: "Community Planning for the Mentally Retarded" and "Development of Community Programs for Mentally Retarded" (Wagg, 1956).

The importance of these sessions was that alternatives to institutions were already being discussed in the early 1950s in Michigan. Other programs were being considered at a time when most states were still concentrating on institutions.

#### The Programs

As alluded to in the law and population sections, hospitals for the retarded grew both in size and in number. The Department of Mental Health (1950) expansion plan proposed building a new hospital in southeast Michigan with a capacity of 2,500. This facility would not open until 1960, but other interim facilities did

provide care. After the 1955 extra session authorized contracting for additional beds, the Department leased space for 250 children at the Farmington Children's Convalescent Center, a branch of the Children's Hospital of Michigan. This facility later became an arm of Plymouth Home and Training School (Department of Mental Health, 1962a, p. 21).

The Michigan Demonstration Research Project for the Severely Mentally Retarded was established in September, 1953 to study how best to work with groups of trainable mentally retarded people. The report stated that programs could be operated by schools, with auxiliary assistance from other agencies. It urged smaller communities (less than 20,000 population) to wait for the creation of other plans, such as sheltered workshops. The report stressed that school programs for trainable level persons should not be established at the expense of programs for the educable (higher functioning) retarded (Andrew, 1959, pp. 7-8).

In May, 1954, the Department of Mental Health began a day school program at the Lapeer facility. Children came to the institution during the day and returned home in the evening. The rationale for establishing the programs was that the institution was now seen as the last resort. In relation to the plan, the Department of Mental Health stated that individuals possessing an I.Q.

of 40 or above should not be institutionalized (Andrew, 1959, p. 7). Such a statement was a radical shift from policy established over the previous 60 years. Not everyone would agree, but philosophically such thinking was the starting point for changing the entire system of care for the mentally retarded in Michigan.

Beginning in April, 1956, 800 people were transferred from Lapeer and Coldwater to the leased Army Station Hospital at Fort Custer near Augusta, Michigan. Originally the facility was designed to be temporary but it remained operational until 1970.

Programs in hospitals across Michigan were severely limited because of staff shortages and overcrowding. All available space was used to house existing residents. The Department of Mental Health (1955b) emergency plan noted that even intended beds for medical patients were used to house people (p. 18).

A family care program was developed to ease overcrowding. This involved placing patients in private homes under hospital supervision. In late 1955, the Department had approximately 200 mentally retarded adults and children in placements, but remained cautious about the program. The emergency plan (Department of Mental Health, 1955b) stated, "Only selected types of patients can be so placed, since a high percentage of mental hospital patients are too ill for such home care, but the



program has proved satisfactory and it vacates some hospital beds for new patients" (p. 21).

Andrew (1959) found that the Michigan Association for Retarded Children was operating 35 to 40 day centers by the end of the decade. These centers were managed and operated by parents and financed by tuition, special collections and Community Chest funds. Andrew (1959) wrote, "MARC and its chapters seem to feel that they are carrying responsibility for children which no state or local agency serves. All evidence suggests this is correct" (p. 14). The Department of Public Instruction felt that trainable children were below the level that the programs were designed to serve and the Department of Mental Health thought that it had no authority to establish local programs. This left a large group of retarded people with no services and therefore little choice but to request placement in a institutions.

The Department of Mental Health position was reiterated by Deputy Director, Dr. V. A. Stehman (1959). In a letter to the State Budget Director he wrote:

I believe that services should be provided at the local level wherever possible and we are moving in that direction here with the establishment of local treatment units throughout the state. This has been minimal and there is no provision for state involvement in these programs. The Department of Mental Health does not feel that it is in a position to establish such local programs and we actually question whether or not we should be involved in such programs. Our development of half-way houses or day-care programs would require legislative

approval. My personal feeling is that the Department of Mental Health should confine its activities to the hospital and institutional treatment of the mentally retarded and serve only in a professional consulting capacity to local programs which should be under the Department of Public Instruction. (pp. 2-3)

The Mental Health Commission addressed this issue in April of 1959. An excerpt from the minutes states,

The Commission next discussed on a broad basis the need for the development of community programs to care for more retarded children at the local level, and thus cut down on the pressure for admission to the state home and training schools. After extensive discussion, the staff was instructed to explore on a preliminary basis the various types of community programs which have been attempted or are being considered, to outline the action that should be taken to develop more such programs, and offer suggestions as to where the major responsibility might lie in the framework of state government, local government, and citizens' organizations to carry forward these programs. (p 2)

Perhaps the best summary of changes that were occurring is contained in the report of the Senate committee appointed in 1955 to study the care and treatment of mentally retarded persons. The committee recommended adding space to institutions, but also recognized that many people were outside the scope of such facilities. They recommended the following:

1. Development of training teams to travel throughout the state and work with local health departments.
2. Training of individuals to provide home care.
3. Development of local nursery schools, training

schools and workshops for the retarded.

4. Expansion of child guidance clinics to serve the mentally retarded.

5. Inclusion of trainable retarded children in local school programs, making it possible for those in institutions to return home.

6. Family counseling available in each county health department in the state.

7. Adoption of uniform and revised commitment laws.

8. Combination of all state hospitals under a single administrator to provide better facility utilization.

9. Provision of scholarships to train doctors, nurses and other mental health personnel.

10. Larger wages and inducements to attract more and better personnel to the mental health system. (Senate Journal, 1955a, p. 48).

Pressing demand for institution placements in the 1950s necessitated that the system of care that had developed for the first half of the twentieth century change. It had become outmoded and could not respond to the needs of the mentally retarded and their families. Other alternatives began to be identified and tested. Many of these would become the laws and programs of the next 25 years.

### Summary

This chapter traced the historical development of Michigan's residential care system for the mentally retarded. It examined the history of Michigan's institution system and showed how it evolved from a small, experimental system of independent hospitals to a large, complex state agency.

Many of the concepts which developed in Michigan paralleled those which occurred throughout the country. Initially Michigan lagged behind other states in providing public services for the retarded. But by the late 1950s Michigan was a leader in concepts of care and treatment as they existed at that time. State institutions had become some of the largest and best equipped in the nation.

The mentally retarded have always been a relatively small group, secondary to other public issues such as population, agricultural and industrial development, as well as establishing sound fiscal policy. Yet, state leaders and decision makers remained aware of the need to provide services for this demanding population.

From the very beginning, in Territorial times, Michigan established public policy to provide for those requiring assistance. Initially such relief was a local responsibility, with county commissioners establishing

and carrying-out policies.

Shortly before Michigan was admitted into the Union, indoor relief became the preferred for providing for the indigent. Almshouses and poor farms were built by counties and larger towns.

Soon after becoming a state the legislature required that counties report the amount and types of relief being provided. From this information the first legislators recommended that poor houses be constructed on relatively large (320 acre) plots of land. These early investments of public money set precedents for the future. Policy would be directed toward provision of indoor relief carried out on farms where residents could work to defray costs.

By 1850 the State of Michigan had included dependent classes of people in its Constitution, a progressive concept for the day. This legislative initiative declared that institutions for the benefit of the deaf, blind and insane were to be fostered in Michigan. The state held to that concept. Asylums were developed to care for the insane which, at the time, included the mentally retarded.

Organization of the early asylums set the administrative structure for such facilities for years to come. A strong hierarchy, it was believed, would ultimately have a positive influence on the patients. As

they were built, each facility was placed under the supervision of a medical superintendent who was the final authority regarding operation of the institution.

By the 1870s, a shift from local responsibility for provision of services to the mentally ill and mentally retarded to state responsibility was well underway. Politicians of the day stated that it was good economic practice and the state's duty to provide for all "unfortunates." These concepts were also found in the national reform movements of the time.

As the state moved into the last quarter of the nineteenth century, attempts were made to make separate provision for feeble-minded people who, for the most part, had become residents of county poor houses. More often than not, they did not fit into available facilities. Others were residents of mental asylums which, some argued, were inappropriate because of their high costs for this untreatable population.

The first institution for the mentally retarded in Michigan opened in Kalamazoo in 1884. It was a private facility, which could be afforded only by a small percentage of State residents. Apparently it was developed in response to the lack of action by Michigan government officials to develop a public institution.

After pressures from both the families and professionals working with the mentally retarded, and

after considerable political maneuvering, an institution was opened in Lapeer in 1895. It was filled to capacity shortly after opening.

Initial attempts were made to keep the institution from becoming custodial in nature. Its original purpose was to form citizens who could become a useful part of society. Administrators stressed training and assisting residents to return to their communities. Following a national trend, the training concept to ameliorate retardation was quickly replaced by one of segregation. By the turn of the century it was evident that the institution for feeble-minded persons was a permanent part of the State's charitable institution system.

In the early 1900s, people who were mentally retarded were viewed as a public menace. Michigan became one of the first states to attempt to pass eugenics legislation in order to stop the propagation of mental retardation and associated vices. The courts struck down early laws but by 1923, Michigan like many other states, had sterilization policies in effect.

Segregation of the mentally retarded became the central purpose of institutions in the early twentieth century. Admissions changed from being voluntary to court ordered and discharge was difficult, if not impossible.

Some of the chief proponents of institutions as

asylums were their administrators. They not only worked to make facilities self-sufficient, but were often the prime advocates of secluding the retarded as a way of protecting society from a deviant class. Their annual reports and speeches evidenced the fact that they fostered the concepts of the retarded as degenerates and the need to safe-guard society.

Development of Michigan's institutions for the mentally retarded were obviously influenced by the ideals common to public administration in the early twentieth century. Reports that justified development of facilities and the use of resident labor based on economy and efficiency are compatible with the ideas of Taylor's theories of scientific management. Stillman (1982) writes, "Taylor's mechanistic ideas of universal laws, the one best way and the dual deities economy and efficiency were clear code words that solved the unconscious yearnings of those in quest of unity, purpose and order in the workplace" (p. 20). The institution of the 1920s and beyond changed from a school, training individual residents, to a mechanistic workplace.

Waldo (1955) notes that during this era public institutions in general underwent great change. He says, "It was an attempt to make government work under the new and more demanding conditions, by increasing the amount of systematic study of the problems and the competence



and training of those entering government service" (p. 19). Institutions for the care and treatment of the mentally retarded were involved in these changes; with both positive and negative results.

The period 1930 to 1950 brought continued growth of the state's institutional system. Although demands for segregation because of perceived deviancy decreased, the population continued to grow. A larger, more complex institutional system continued to evolve.

In terms of public administration the system used classical Hamiltonian concepts to cope with its problems. For example, authority was centralized instead of being dispersed in a board of trustees and the importance of professionalized administration (physicians) was increasingly stressed. In addition, superintendents continued to maintain administrative power commensurate with their responsibilities.

By 1950, hospitals for the care and treatment of mentally retarded people had become fully institutionalized in Michigan. The need for facilities and their specific functions were no longer questioned. Yet limited access to these facilities, even in light of increased appropriations, and severe over-crowding began to call into question their ability to serve the population in need.

By 1959 public residential care and treatment of

mentally retarded people had grown to a large state-wide system. Over 11,000 people were residents of seven state funded facilities. In addition, the development of community programs had started, in the form of clinics and day centers.

Care was no longer left to an isolated 200 bed facility, under the supervision of an independent superintendent. The activities of the Michigan Department of Mental Health now occurred in conjunction with other state departments such as Public Health and Public Instruction. They were observed by the legislature and Executive branch. Citizen's groups, such as the Association of Retarded Citizens, were also involved. What had begun as a small, isolated endeavor in 1895 had become a large governmental bureaucracy some 65 years later. As will be discussed in the next chapter, the transformation of the public care system would continue in the 1960s, '70s and '80s. Alternatives to the large, isolated institution would be developed as the laws, population and programs related to the residential care and treatment of the mentally retarded changed.

## CHAPTER IV

### CARE IN MICHIGAN: PRESENT-DAY (1960-1983)

Residential care for the mentally retarded had become a major enterprise in Michigan by 1960. The system, which began in 1895 as one school with 44 staff and 200 residents, had grown to seven institutions (including the contracted Wayne County Training School) housing 11,200 people with 3900 staff. The Department of Mental Health (1960a) Program and Activities Report indicates the size and complexity of the system. First admissions of the retarded to training schools averaged about 1,000 per year. An additional 500 were transferred from other hospitals. Only 91 people were discharged from the system, 166 died, 607 were transferred to other state facilities, 200 were placed in foster homes and 462 were in independent or family placements on a trial basis (p. 15).

After being reduced in the 1950s the waiting list in 1960 was once again over 1,200. The Department of Mental Health (1960a) report notes that even if facilities were available to house those on waiting lists, intake would still exceed placements. The report added, "The annual rate of increase appears to be steady and there is no

expectation that any treatment methods or other discoveries will alter this rate in the next several years ahead" (p. 4). Figure 4 shows how the institutional population continued to increase until the mid-1960s, when radical changes began to take place in this system. This chapter focuses on significant changes in the Michigan Department of Mental Health, and its care and treatment of mentally retarded people. Review of changes in laws, client population and programs during the period 1960 to 1983 complete the history of Michigan's care for the mentally retarded.

#### The Framework

In order to view the policy-making aspects of this period, a modification of a model suggested by the Council of State Governments (1978) in The Dynamics of Public Policy and the Developmentally Disabled will be used. This model was developed as an aid in interpreting the dynamics of policy formulations. Figure 5 shows its general form.

Status elements are existing factors which must be modified in order to implement policy. Change forces are depicted as the outer ring in Figure 5. The Council of State Governments (1978) defines change elements as "the sources of pressure to bring about change through interaction with status elements" (p. 11). The change

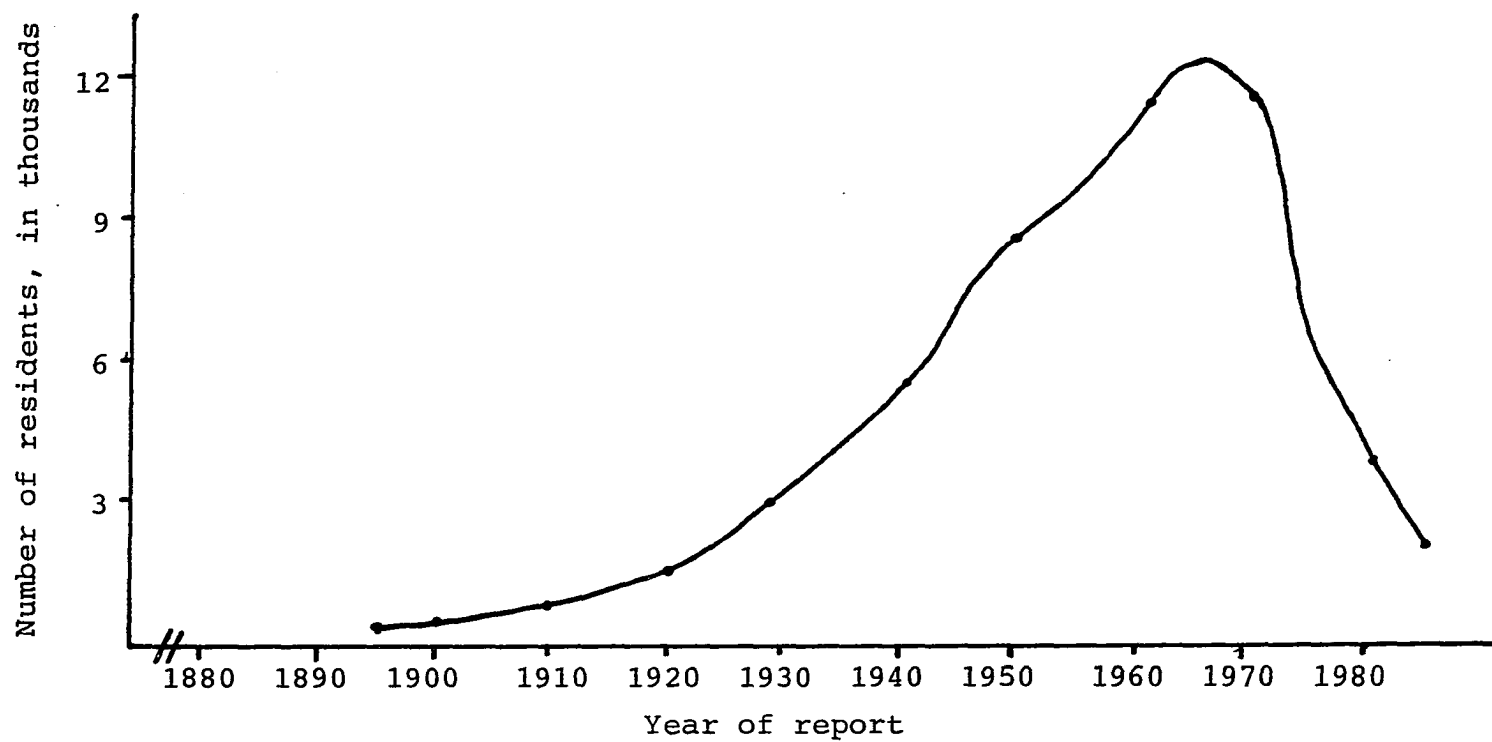


Figure 4. Total Populations of Mentally Retarded People in Michigan Public Institutions for the Period 1895 to 1985.

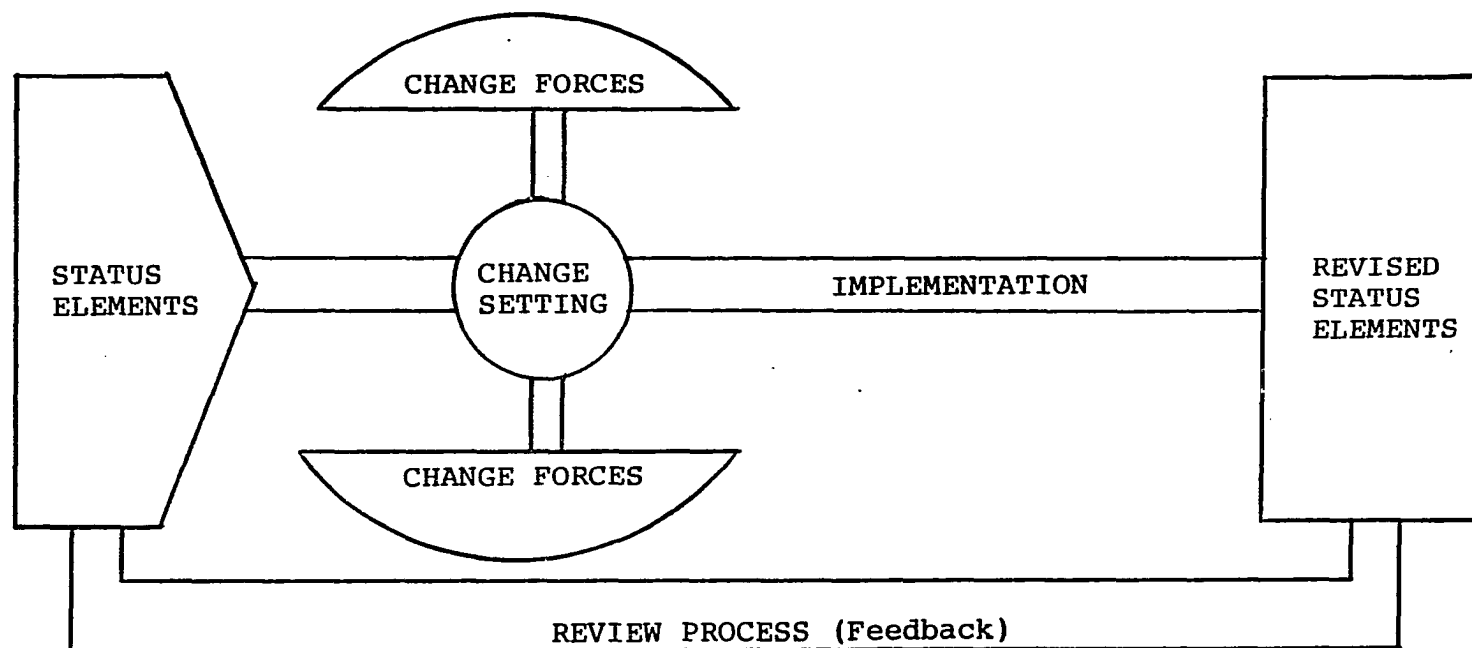


Figure 5. A General Framework for Assessing Factors that Influence Policy Change.

setting is the point at which the interaction of change forces with existing status elements results in revised status elements. In the model, the change setting is represented by the inner circle. Revised status elements are the box on the right. The fifth element is the review process. This is the feedback loop, or mechanism by which the impact of policy implementation is measured. In a governmental setting this is the process which places the status elements into a position of interaction with the change forces, and may eventually lead to implementation of revised or new policy.

Figure 6 shows a modified form of this model. Status elements are those used in Chapter 3: client population, laws and regulations, and existing programs. Change forces include resource availability, judicial opinion, social consensus, interest group actions and governmental initiatives. The change setting is the forum for policy formulation, typically legislative and executive branches of government at various levels. Revised status elements are the client population, laws and regulations and existing programs as they are changed by implementation of new public policy. The review process is the mechanism that allows for evaluation and assessment of revised status elements and, over time, places them back into the change setting to interact with change forces. This allows for the possibility of

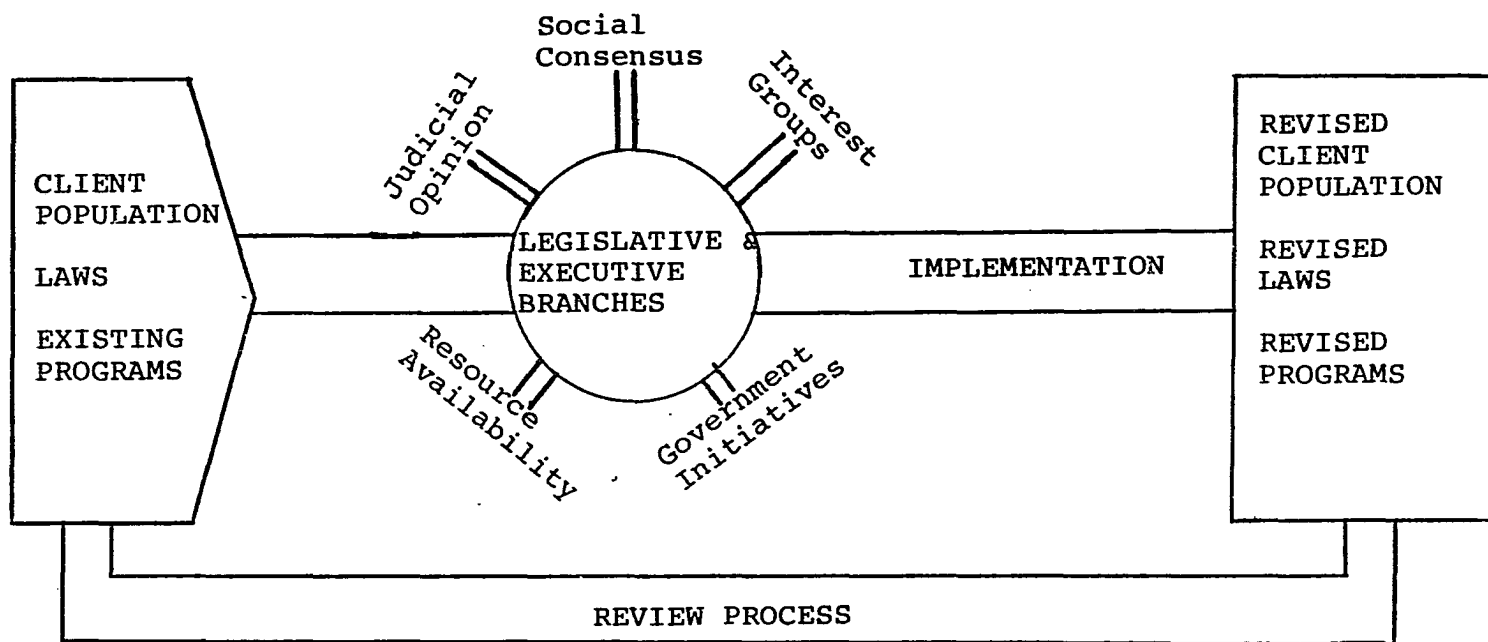


Figure 6. A Specific Framework for Assessing Factors That Influence Residential Policy in Michigan.



additional change.

The three status elements of law, client population and programs were selected because they represent the people involved and the mechanisms (laws and regulations) used to define and carry out public policies related to the residential care and treatment of people labeled as mentally retarded in Michigan.

The second component in the framework (Figure 6) is comprised of change forces. These are the factors or sources of pressure which can bring about change in public policy.

In 1978, a conference on Public Policy and the Developmentally Disabled involved representatives from state developmental disability councils, federal offices of Health, Education and Welfare, the U.S. Justice Department, administrators of mental retardation agencies and state legislators from several eastern states. They identified five first-order change forces which impacted upon federal policy. They were: court decisions, client advocacy, social consensus, availability of resources, and federal initiatives (Council of State Governments, 1978). It was the consensus of this conference that these factors were seen as most directly influencing federal policy development in the area of mental retardation and developmental disabilities (p. 6). Other issues such as technologies, social theories and public

awareness were influential, but usually to a lesser degree. Such second-order elements were thought to filter through the five first-order concepts and, therefore, had less direct impact on policy implementation.

Based on the findings of the Council of State Governments (1978), the following change forces serve as the framework for this chapter. They include: governmental initiatives, interest group actions, social consensus, resource availability, and judicial opinion.

Governmental initiatives are general policies or rules implemented by governmental agencies and legislative bodies that are designed to achieve a particular social goal.

Interest group actions as a change force include organized efforts by client groups, families and advocacy organizations. Professional opinion and activity should also be considered, including interactions of various agencies and attempts at interagency cooperation as they impact upon the selected status elements (Sellin et al., 1974).

Social consensus is defined as public support for a particular social goal. As a change force, social consensus may be a perception that the general public favors a social concept or idea.

Resource availability refers to the quantity of

resources available and the demand on them. This is often related to economic factors such as spending allocations and budgets, but may also include program availability and access to technological advances.

Judicial opinion includes court cases that may act upon status elements, such as existing programs, and provide mandates for the achievement of certain goals. Chapter 2 offered examples of court intervention in existing programs.

A third element in this framework is the change setting, the forum for interaction between status elements and change forces. A change setting could be the legislative or executive branches of state government or similar bodies at other levels, such as boards of commissioners, city councils, housing commissions and/or mayors. It should be noted that the executive branch also includes various state departments and the staff who work within them.

Interactions occurring the change setting are crucial to policy change and implementation. As the Council of State Governments (1978) noted, "Public policy is essentially capable of implementation when the status elements are modified by legislative action, or administrative regulations, or by some combination of the two" (p. 13). In other words, public officials assess the influence of the change forces and then determine the

types and magnitude of change to execute.

Finally, it must be remembered that the reshaping of status elements is not an instantaneous event, but rather a process that occurs over time. This review process is the feedback loop or mechanism by which the effect of policy implementation is measured and modifications made over time.

To summarize, the framework used in this chapter includes status elements, change forces, the change setting, revised status elements and the review process. These components allow assessment of the formation of public policy, the factors which impact upon it, its implementation and modification over time. The central focus of this chapter is the significant public policy related to the residential care and treatment of people labeled mentally retarded in Michigan. The framework assists in organizing the presentation of these policies.

It must be stressed that the framework as modified is a general blueprint to assist in assessing policy development in Michigan, not a specific mechanism or paradigm to systematically analyze every aspect of that policy. This type of assessment is what Dror (1986) refers to as historic process. He sets this against a systems view of policy making. He states, "It seems that the concept of process is superior for handling many subjects, especially when longitudinal dynamics are

considered" (p. 8). The historic process, as Dror uses it, is a vehicle for analyzing unfolding realities in a time of "shifts and jumps in policy issues" when traditional paradigms are difficult to apply (p. 23).

The use of this type of model to evaluate the factors which influence policy development has an iterative nature to it. As Quade (1975) points out, one attempt at resolving a problem is seldom enough. Successful analysis depends upon a continuous cycle of formulating the problem and then following the process through an analytical cycle (Quade, pp. 50-52). The history of the care and treatment of the mentally retarded in Michigan demonstrates such a cyclical process.

As a historical process, events in the Michigan Department of Mental Health in the 1960s, '70s and '80s can not be separated from previous policy development discussed in Chapter 3 or from national trends reviewed in Chapter 2. This Chapter shows how earlier policy evolved into the present state policy and the factors influencing this evolution.

### Background

As mentioned, Michigan's Mental Health system had become a large and complex bureaucracy by the 1960s. The Michigan Department as a whole employed one-third of the

total state work force and had a budget of approximately \$75,000,000, exclusive of building and capital outlay (Department of Mental Health, 1962a, pp. 23-24). A Department of Mental Health report (1962d) noted that over 70,000 people were treated annually in state operated hospitals, clinics and family care programs (p. 3). Through the 1950s the number of institution beds for the mentally retarded in Michigan increased by 39 percent. Yet, because the number of children in the general population had grown by 48 percent during the period, waiting lists still existed (p. 5).

In 1960 a construction moratorium caused increased overcrowding in facilities. This meant that care and treatment in many state hospitals fell below minimum standards by the Department's own assessment. The December, 1962, report stated, "Although these hospital programs have been improved there still remains serious deficits in their capacity to give acutely needed treatment and to provide minimum, decent, humane care for long-term chronic patients" (p. 9).

In January, 1959, Governor G. Mennen Williams established a Citizen's Mental Health Inquiry Board to investigate charges of patient abuse and to inquire into the over-all administration of the State's mental health program. This Board concluded that each institution operated independently, and there was little coordination

of activities and services. The report stated, "In the overall picture there is relatively little coordination, communication or cooperation between them. There is also little coordination with other agencies outside the Department of Mental Health" (Department of Mental Health, 1960c, p.4). This created increasingly poor care with few prevention or follow-up services.

The Inquiry Board's report also highlighted a major administrative problem in the department. Institution administrators were in control of the department, not the central office. The committee said, "When we look historically at the development of the system, we find that individual hospitals were developed by strong, capable leaders. These hospitals were developed and became excellent examples throughout the country of progressive care" (Department of Mental Health, 1960c, p. 7). The end result was weak central administration. The committee recommended that the departmental organization structure change, because there were functions which could no longer be carried out effectively or economically at a local level.

Finally the Inquiry Board concluded that the Mental Health Commission was part of the problem. The report added, "Students of public administration have long condemned the commission form of organization for operating departments of government" (p. 11). It was recommended

that the department director report directly to the governor and that the Commission take on an advisory role.

One other piece of background information must be presented in order to fully understand the status of residential care and treatment for the mentally retarded in 1960. In the mid-1950s the Michigan Association of Retarded Children began to formulate state-wide goals. These eventually included the following:

1. The development of adequate institutions without overcrowded conditions.
2. The establishment of diagnostic centers to determine the existence of mental retardation.
3. The development of screening programs to detect mental retardation in young children.
4. Additional research into the causes, cures and prevention of mental retardation.
5. Development of emergency shelters for short term care of mentally retarded children.
6. Smaller, friendlier institutions.
7. Increased employee/patient ratios at state institutions.
8. Changes in the commitment process so that families would not have to go to court to gain institutional admission.
9. Changes in parental financial liability to lessen the financial burden of placement.



By 1960 the Association was working with the Department of Mental Health, the legislature and the Governor's office to address these issues. Leaders in the organization believed that these goals would create better institutions and improve care and treatment for their children (Trumble, 1986).

Many of the issues raised by groups like the Association of Retarded Children and the Board of Inquiry would be considered and debated by the legislature. Several would become law during the period discussed in this chapter, as will be seen in the following section.

#### The Law

The Department of Mental Health's analysis of its 1961 appropriations bill indicates its emphasis on programs for the mentally retarded. Director Charles Wagg (1961, p. 4) indicated to the governor's budget office that the department needed funds for the following areas related to retardation:

1. Completion of Plymouth State Hospital to accommodate 2500 residents.
2. Transfer of the Howell tuberculosis facility to the Department.
3. Increased nursing coverage for severely retarded residents, especially on the night shift where many units had no assigned personnel.

4. Expansion of family care programs to place more people into community homes.

5. Creation of a community service program to assist the families of the retarded in achieving access to services in their local communities.

6. Opening of new community clinics to service those retarded who could not be admitted to institutions. This list is similar to the one established by the Association for Retarded Children.

In addition to appropriations, several other pieces of legislation impacted upon the care and treatment of the retarded. As was briefly discussed in Chapter 3, recommendations had been made for several years to transfer unused tuberculosis facilities to the Department of Mental Health. Various directors of the Department of Public Health had opposed these measures. Public Act 111 of 1961, which was a supplemental spending bill, did transfer the state sanatorium at Howell to the Department of Mental Health. Not only were the buildings transferred, but all personnel and equipment that were not need for tuberculosis care also became part of the Department (p. 129). Two years later a similar transfer created Gaylord State Home (Department of Mental Health, 1967, p. 63).

In 1962 several additional pieces of legislation were introduced that indicated a changing view of the

population. House Bill 155 proposed limiting the liability of parents for care and maintenance of mentally retarded children in institutions. Arguments were made that parents were being taxed double by paying regular taxes plus a fee to the institution. The legislation died in committee (Journal of the House of Representatives, 1962, p. 2258).

Senate Bills 1176 and 1177 amended previous acts to remove epileptic persons from the provisions of the sterilization acts and prohibitive marriage laws. This legislation was introduced by the Department of Mental Health because, "Epilepsy today is a well controlled disease and individuals so afflicted should not be under the same stigma as the insane, feeble-minded, moral degenerates and sexual perverts" (Wagg, 1962, p. 1). Interestingly, the department, acting as the change force in this situation, still classed the mentally retarded with moral degenerates and did not move to exclude them from the laws.

House Bill 505 of 1962 is an example of legislation which had interest group support (parents) and governmental support (Mental Health and Public Health) but could not garner enough Senate support for passage. This bill proposed testing all newborn infants for phenylketonuria (PKU) to diagnose and prevent retardation. The bill passed the House but died in the

Senate appropriations committee because it was thought to be too costly (Senate Journal, 1962, p. 950). In response, House Resolution No. 132 was offered. It noted that such tests could be preventative in nature and that the Legislature failed to pass mandatory testing. The resolution urged all physicians in the state to administer PKU tests and report findings to parents (Journal of the House of Representatives, 1962, p. 2055).

#### Community Mental Health

Although PKU testing, revision of marriage laws, parental liability and creation of more institutional beds were significant issues in the early 1960s, the matter of services outside the institution was also of prime concern during these years. Beginning in 1960 and continuing for the next five years there was on-going debate over the provision of community mental health services. The central argument regarding establishment and implementation of the community mental health law was, what entity would have administrative control of the system? The following pages outline the development of this significant public policy.

The Department of Mental Health's (1960a) program and activities statement mentioned that for twenty years the department had been developing community clinics as part of its overall plan of prevention and early

treatment. The report added, "Although the statutory jurisdiction for the community clinics is with the Department of Mental Health, the Department shares certain responsibilities through a partnership arrangement in which the Department represents the state and a local citizen board represents the community" (p. 6).

In September, 1960, the Department of Mental Health issued a report entitled "Community Mental Health Services in Transition." It stated that the traditional ideal of the state holding the full and sole responsibility for treatment and care was gradually changing. The report added, "Community Mental Health (CMH) services are not an exclusive state function and the development of more local responsibility is an important and continuing goal" (Department of Mental Health, 1960b, p. 3).

As services changed, the report continued, the role of the department would shift from that of program planning, supervision and guidance to a regulatory and inspection function. However, before this could happen a number of problems had to be resolved. These included (a) funding of local programs, (b) definition of what services should be provided, (c) integration of CMH programs and those of other agencies, and (d) preparation to meet the high service demand that would exist

(Department of Mental Health, 1960b, p. 11).

In May, 1961 separate resolutions were introduced in the House and Senate regarding the department. Each called for the creation of special committees to study mental health in Michigan. House Resolution No. 102 (Journal of the House of Representatives, 1961) began, "Whereas, Allegations of ineptitude regarding the operations of the Michigan Department of Mental Health have been made to the Legislature..." (p. 1460). This resolution died in committee.

The Senate counterpart, Resolution No. 59 (Senate Journal, 1961) was more specific about the increasing demands for community mental health services. It stated that local services were limited and established a committee to study possible community mental health legislation (p. 873). The committee worked between the 1961 and 1962 sessions and presented its report on May 17, 1962 (Senate Journal, 1962, pp. 1431-1434).

The senators met with numerous advocacy groups, the director of the Department of Mental Health, probate judges, practitioners and reviewed programs in New York and Minnesota. They also reviewed literature from around the country.

The committee findings show clear disagreement between the senators and the department director. The report begins:

Testimony received by the committee, except that from Department of Mental Health personnel, indicated that Michigan's community mental health services program is limited almost entirely to 18 child guidance clinics with a few branches and six adult mental health clinics. (p. 1432)

The committee found a lack of coordinated effort in Michigan among health, welfare, legal and education agencies planning for new services.

It was also observed that the department controlled all local services. Local boards had no final decision-making powers. In New York and Minnesota, local control produced efficient and accessible services. The report said, "The basic principle in both of these states is that planning, initiation and administration of local level services should lie with the community" (p. 1432).

The committee concluded with a list of ten recommendations which included provision of rehabilitation services, consultation with community agencies and local program control. These were added to Senate Bill 1250 of 1962.

This proposed legislation was taken almost verbatim from a format suggested by the Council of State Governments. Their publication was titled, "A Suggested Act on Community Mental Health Services" (Department of Mental Health, 1961).

Parallel to the Senate Study Committee the State Mental Health Commission established a Study Commission

on Community Services in September, 1961 to look at financing, personnel, board structure and the general scope of the problem.

On January 9, 1962 the Mental Health Commission adopted a set of policies developed by the committee. Although similar to the Senate recommendations, there were several that were clearly in opposition. For example, recommendation 1 read:

To write into Michigan law the present Michigan plan which provides for joint state and community operation of community mental health services, keeping with the arrangement in the form of a partnership or joint undertaking, with the state being the primary partner and the community a secondary partner, the partnership arrangement to include financing and administration. (Department of Mental Health, 1961)

In other words, the recommendation was that the status quo be maintained.

Recommendations 9 and 10 suggested that the department appoint at least one community board member and that employees would be part of the State Mental Health System. Both recommendations countered the idea of local control suggested by the Senate. The recommendations of the Mental Health Commission were incorporated into House Bill 99 of 1962.

On January 17, 1962, Governor John Swainson addressed the legislature on the mental health needs in Michigan. He stressed that communities were being included more and more in mental health treatment



programs. He added, " It is vital, however, that these services be provided most effectively and efficiently as possible, with solid focus on the total problem of mental health in Michigan" (p. 34). Therefore, he urged legislation to provide for joint state and community operation of mental health programs.

Director Charles Wagg (1962) sent an analysis of House Bill 99 to the governor on February 5, 1962 and an analysis of Senate Bill 1250 on March 14, 1962. The first memorandum indicated departmental support of the House Bill because it was legislation similar to that existing in other states, and it would create broader community services.

Wagg (1962) took a negative position on Senate Bill 1250. He argued that if control of programs was given to local authorities, services would diminish in quality and quantity. He added, "Michigan has been developing for twenty years a community mental health program under joint control. The Mental Health Commission feels the Michigan program should not be thrown aside, but should be improved upon by retaining the present features of jointness or partnership" (p. 2).

Both bills died in committee in their respective houses. But the issue was far from dead. The Senate established another study group stressing in their resolution that there was an urgent need for community

services (Senate Journal, 1962, p. 1555). The report of the committee recommended administration of services at a local level, with state supervision. Senate Bill 1074 of 1963 resulted from this report.

After a series of amendments, and introduction of a substitute bill, S.B. 1074 passed the Senate and House and was approved by the governor. It became Act 54 of 1963. The Senate established a committee to oversee the implementation of the legislation by the Department of Mental Health (Senate Journal, 1963, p. 127). The committee report in the Senate Journal (1964) found that implementation of the Act began slowly. The report stated:

Public Act No. 54 of the Public Acts of 1963 became effective September 9, 1963. It is enabling legislation whereby county boards of supervisors, or in the case of Detroit the City Council, must resolve to take advantage of the act's benefits in order to qualify for them. In the seven months since the act was effective, three counties have formally come under the act. Fourteen county's boards of supervisors have authorized studies preparatory to coming under the act, and in four counties citizen studies have been launched hopeful of convincing their boards of supervisors to act under Public Act No. 54. (p. 1494)

The Senate passed a Concurrent Resolution (No. 49) asking that the rules for the act developed by the department be either revoked or altered to conform to legislative intent. The resolution gave the following reasons for this request:

1. The degree of autonomy to be given local boards

in return for their contributions of money and services was not clear;

2. Local community participation was undesirably restricted in that the kind of facilities and type of personnel which could be used were unduly limited;

3. Preventative mental health and mental retardation activities of health departments, social agencies and other groups were sharply curtailed, with the result that community programs would be unworkable and unavailable for many years; and

4. The general standards of qualified personnel employed by other agencies were not clear. (Journal of the House of Representatives, 1964, pp. 1789-1790).

The resolution passed the Senate but failed in the House and therefore was not enforced.

The development of community mental health legislation in Michigan is an example of the iterative process that takes place in policy formulation. The existing status element of a law which placed full responsibility with the State's Department of Mental Health was changed, over time, by a number of change forces impacting upon the law. These change forces included government employees, interest groups, legislators, social concepts (what other states had done) and resource availability (cost arguments for an independent system versus a DMH run system).

It is observed that the change was not as extreme as first proposed. The existing bureaucracy, even when under scrutiny for "ineptitude" and poor management, was able to maintain a certain amount of control.

The significance of this changed status element was that it altered formal public policy in Michigan. Residential care and treatment of mentally retarded people was no longer the sole domain of the state Department of Mental Health, and no longer had to be provided in isolated state hospitals.

Refinement of Act 54 continued beyond 1963. In the first year that it was effective no legislative appropriation was authorized to implement programs. The second year brought a \$1.5 million appropriation for planning and coordination activities. The original law also provided for state support of 40 to 60 percent of a community board's budget, with a one dollar per capita ceiling on funds. A means test for services was also incorporated into the law, excluding those who could pay for services. Amendments in 1966 changed the matching ratio to 75 percent state support and eliminated both the per capita ceiling and means test (Department of Mental Health, 1967, pp. 54-55).

#### Administrative Changes

Two other changes in the law influenced operation of

the Department of Mental Health and its treatment systems. In 1963, at the same time community mental health legislation was being debated, a bill was introduced in the House of Representatives to abolish the state hospital commission, require the director to be a psychiatrist and be appointed by the governor. Public Act 236 of 1963 was approved on May 23. The legislation also established a 12 member advisory council which was consultive in nature and had no administrative authority (Journal of the House of Representatives, 1963, pp. 1629-1633, 2037).

This legislation was introduced in the session after strong stands against an independent community mental health system were advocated by both the commission and the DMH director. The new legislation effectively eliminated both the commission and the director. (Wagg was not a psychiatrist and left the director's position in 1964.)

In 1963 a revised State Constitution was also approved. Public Act 380 of 1965, the Executive Organization Act, implemented a constitutional provision that provided for a reduction in the number of state departments to no more than twenty. Mental health became one of nineteen state departments (pp. 750-751). As the Organization Act was being formulated, there was discussion regarding placing the department back under a

commission system of administration. In a memo to Governor George Romney, Wagg (1964) strongly urged that the change not be made. He argued that such a change would be counter-productive to the provision of good services in Michigan. Thus legislative and administrative action influenced the development of the modern Department of Mental Health.

#### Mental Health Statute Revision

The next major legislative action impacting upon the residential care and treatment of people who were mentally retarded was revision of Michigan's mental health statutes. Over the years, laws related to mental health had become complicated and were found in a number of different public acts. In the Fall of 1968, the Department of Mental Health presented to the governor a recommendation that a major in-depth study and rewriting of the state's mental health laws be initiated.

The recommendation was predicated on the idea that state mental health law should serve as a sound and enabling base for addressing citizens' mental health needs. The proposal pointed out that there were deficiencies in existing laws stemming from patchwork and haphazard amendments to laws over a period of years. The Department of Mental Health (1970) Review Commission noted, "Through the passage of time the Legislature had

dealt with hundreds of particular statutory problems, but never with the total situation" (p. 1). Problems were many and interrelated, and therefore could not be handled in an isolated fashion.

The Department proposed a two year study project to update Michigan's mental health laws in their entirety, by joint executive and legislative action. It was suggested that the matters involved in rewriting the state's mental health laws needed the participation, understanding, support and backing of a number of important groups (change forces), such as: the judiciary, the State bar, the medical and psychiatric profession, other professional groups working in the mental health field, interested citizen organizations and the legislature. In order to achieve that end, it was proposed to permit the involvement and participation of such groups in the entire process, so that their support would exist at the time of implementing the findings. It was further proposed that a skilled staff be assembled to perform the necessary technical and research work, and to prepare position papers and proposals for consideration and action of the study commission (Department of Mental Health, 1970, p. 2).

Governor William Milliken endorsed the proposal and incorporated it as part of his budget message in 1969. He requested an appropriation of \$200,000 to fund the two

year project.

On May 6, 1969 Milliken issued Executive Order 1969-5 to create a study commission. The order read in part,

Whereas, recent decades have witnessed precipitous change and monumental growth in the science of mental health; and,

Whereas, as a consequence thereof, much of Michigan's mental health law has not kept pace with new techniques of diagnosis and treatment, and has thereby been rendered archaic or unworkable;...

Therefore, I, William G. Milliken, Governor of Michigan, pursuant to Act 195 of the Public Acts of 1931, do hereby ordain and establish within the Executive Office of the Governor, the Michigan Mental Health Program and Statute Review Commission. (Journal of the House of Representatives, 1969, p. 1561)

The Governor appointed 21 representatives from the courts, the legal profession, the Association of Retarded Children, the Mental Health Society and other groups to the commission. He also pledged that the commission would work with appropriate Senate and House committees. The group was charged with responsibility for reviewing, analyzing and recommending new language, where needed, in the Michigan laws governing mental health. A Department of Mental Health (1969b) Bulletin stated, "A major objective of this joint executive-legislative effort will be to develop laws to provide improved access to mental health treatment for all of Michigan's residents" (p. 1). The commission began its work in March, 1970.

Simultaneously, the legislature decided it should be



officially and directly involved in studying of the mental health laws. In the summer of 1969 it established a special subcommittee, the Michigan Legislative Committee to Revise the Mental Health Statutes. The committee hired a staff directed by Dr. Philip Arben.

Arben (1970), in a presentation to the Governor's Commission, stated that the legislature had directed him to clarify the present statutes and to introduce changes as needed. He indicated that a codification of the laws should have four areas of emphasis:

1. Admission and discharge procedures for both the mentally ill and mentally retarded.
2. Civil and legal rights.
3. Finances, both charges for services and distribution of costs between state and local entities.
4. Duties, powers, responsibilities and organization of the Department of Mental Health (p. 9).

Minutes of the Governor's Commission indicate that this group took a similar approach to reviewing the statutes, although some degree of tension and competition existed between the two committees. Arben (1970) repeatedly referred to the revisions as a function of the legislature and to his committee as a "creature of the legislature." In testimony before the House Mental Health Committee (February 7, 1974) he reiterated his position. He said, "If you're going to revise a

substantial body of statute this is a function of the legislature and not of the executive branch of government." He added, "I think, in our work, we have tried very hard to stay true to that original conception; that this was a product of the Michigan State Legislature" (p. 2).

Both groups appear to have functioned parallel to each other. The Legislative Committee drafted the actual language of the bill that was presented in 1973 and debated in 1974.

The Governor's Commission was staffed primarily by Department of Mental Health employees under the supervision of Directors William Anderson, M.D., and E. Gordon Yudaskin, M.D. Campbell (1986), in his research, found that the prime functionary behind development of the revised code was Charles Wagg, former director. Wagg served as a consultant to the department between 1971 and 1974, and was credited as the architect of the statutes that were finally passed.

Minutes of Governor's Commission meetings indicate that extensive testimony was received from a broad range of individuals and organizations. At the June 15, 1970 meeting, the Michigan Association for Retarded Children offered a series of recommendations. These included:

1. All laws pertaining to the mentally retarded should be separated from those related to the mentally

ill.

2. The words feeble-minded, idiot and imbecile should be dropped and language more acceptable to society should be added.

3. Laws favoring parental liability should not be changed.

4. The ideas of court commitments and the removal of an individual's birthright should be diminished.

5. Act 54 Boards should be directed to provide more services in the community (Governor's Statute Commission, June 15, 1970, pp. 2-3).

Shortly after his appointment as Director of the Department, E. Gordon Yudaskin testified before the commission that he believed services needed to be consolidated and better coordinated. He observed that the Director of the Department, hospital superintendents and Community Mental Health Boards were isolated from each other and needed to be administratively brought together. He also believed that services for the mentally retarded and mentally ill should be administered by a single state agency, with separate organizational structures for delivery of services (Governor's Statute Commission, August 3, 1970, pp. 5-8).

Consideration of how services for the mentally retarded should be delivered was a major topic of discussion throughout the deliberations. Various options

were proposed and can be summarized as follows:

1. A separate state level Department of Mental Retardation should be established separate from the Department of Mental Health.

2. The name of the department should be changed to the Michigan Department of Mental Health and Retardation.

3. Responsibility for the mentally retarded should be moved to the Department of Education.

4. The department should have two distinct divisions, one for the mentally ill and one for the mentally retarded.

On July 19, 1971, it was recommended and accepted by the Commission that mental retardation services stay within the Department (Governor's Statute Commission, p. 3).

By early 1972 the Governor's Commission had finished its study and recommendations were sent to the legislature for consideration and action. Recommendations related to the mentally retarded included the following:

1. A separate section of the mental health code covering particular aspects of the admission, discharge and guardianship of the mentally retarded should be enacted so that the special needs of the mentally retarded would be addressed.

2. The civil rights and other protective provisions in the mental health code should cover the mentally ill

and mentally retarded alike.

3. The mental health code should exclusively use the term "mentally retarded" in place of the derogatory terms used. Mental retardation should be defined separately from mental illness by reference to accepted professional, scientific and legal measurements and qualities. I.Q. should not be the sole determinant.

4. The mental health code should provide for a simple, voluntary admissions procedure for the mentally retarded, and its use should be encouraged.

5. If commitment through the courts was used, it should be a simple process.

6. The least restrictive placement should always be sought and no placement in an institution should take place if a person could be served as well by other resources.

7. The mental health code should provide reasonable financial assistance for families purchasing private services for a mentally retarded person while on a waiting list for immediate admission to a state institution.

8. The mental health code should provide for periodic review of the status of the mentally retarded, and for restoration of civil rights and legal competence when these had been removed in a court proceeding.

9. Final or conditional discharge should be

authorized when the individual could be better served in other than an institutional setting. A person should not be placed in an institution forever.

10. Public guardianship should be provided to individuals who have no family to provide this function.

11. Guardianship should be used to assist and not restrict a person. (Governor's Statute Commission, January 18, 1972, pp. 1-4).

In February, 1974 House Bill 5684 was introduced having 58 Representatives as co-signers. During February and March public hearings were held throughout the state to gather testimony and suggested amendments from a broad range of consumers, practitioners and legal authorities. A substitute bill was prepared and passed by the House in May, 1974. During June the Senate considered and amended the legislation and in late July, having passed both houses, the bill was sent to the governor. It was signed into law as Public Act 258 of 1974 on August 6.

Recodification of Michigan's mental health statutes was formally a six year process. It was a process of taking a multiplicity of status elements (existing laws), placing them in both the legislative and executive change settings and allowing literally hundreds of change forces to mold them. This occurred over time, with each cycle refining the code by adding, deleting and changing the language of the previous cycle.

This development was an extended process that began, according to Dr. Vernon Stehman (personal communication, February 27, 1985), former department administrator, with enactment of Act 54 of 1963. It was then that the system began to change by transferring responsibility and authority from the state system to local systems. The Mental Health Code was an extension and amplification of previous attempts at policy change.

In his 1975 State of the State address, Governor Milliken stated that the act would have a dramatic effect on mental health services and how they would be delivered in the future. He said, "The new Mental Health Code brings together in a single, ordered statutory framework all of the laws of Michigan that deal with mental illness and mental retardation and establishes the basis for a single, unified mental health system integrating State and community services" (Milliken, 1975, p. 63).

Implementation of the public policy was another matter. Paul Tarr, staff person hired to prepare rules and regulations to implement the Code, stated that although the law brought a new direction to the system, it also caught the Department by surprise. Tarr (personal communication, February 13, 1985) explained that it appeared that the legislature would adjourn for the summer without passing the Code, but a court case involving institution commitments forced them to expedite

the process. He added, "When they passed it the Department was caught flat in the summer trying to pull it all together with the understanding that they had to have it implemented by November the 6th."

Patrick Babcock (personal communication, March 25, 1985), current department director, states that the community control and planning portions of the Act were not actually implemented until the 1980s, years after the law was passed. Referring to the 1978 Headlee budget amendment to the State Constitution (Section 30) he said, "If Headlee hadn't come and the budget crisis hadn't come, that policy would still be something written in the mental health code that really was not implemented." David Weiner (personal communication, October 31, 1984) substantiated Babcock's contention. He stated that the amendment required 41.6 percent of state dollars to go to local programs. Therefore, there was a shift to funding Community Mental Health agencies. He said, "This forced a change from a centralized Department system to the Community Mental Health system."

It can be seen that public policy, which formally developed between 1968 and 1974, was influenced by change forces prior to and after iterations through developmental cycles. Previous law, constitutional amendments and resource availability also influenced development of community care for the mentally retarded



in Michigan.

### Housing Legislation

In 1976 the legislature passed a set of five acts designed to aid development of community based services as an alternative to institutionalization. Public Acts 394, 395 and 396 were amendments to State zoning and land use laws and Public Acts 397 and 398 were amendments to foster care licensing laws. In his State of the State address Governor William Milliken (1976) urged legislators to take action. He said, "It is no secret that some communities in this state discriminate against the mentally ill and mentally retarded through restrictive zoning ordinances. It is time to stop that discrimination and its concomitant, the mental health ghetto" (p. 64).

These laws were developed and introduced in the House of Representatives to address the problems of discriminatory zoning practices and over concentration of foster care homes. As the House Legislative Analysis Section report (1976) states, "Zoning ordinances have been used to exclude foster care facilities from residential areas. As a result, these facilities have tended to cluster in areas without zoning restrictions creating in effect ghetto situations" (p. 1).

These legislative amendments provided that:

1. Cities, villages, townships, or counties could not exclude from residential zoning districts homes which provided residential services for six or fewer persons.

2. Homes which qualified under the act had to provide 24 hour per day supervision.

3. No licenses could be granted to a new residential home if another state licensed home was located within a 1,500 foot radius, unless permitted by local zoning ordinances. No licenses could be granted in the city of Detroit if another home was located within 3,000 feet.

4. Local governing bodies could file complaints to have a home's license suspended, denied or revoked.

5. The state licensing agency had to resolve complaints within 45 days. Failure to resolve complaints within the 45 day period would preclude issuing or continuing a license.

6. Transitional homes serving persons released by correctional facilities were not covered under the amendments.

7. At least 45 days before a license was issued, a municipality had to be notified so it could review the number of existing or proposed homes within 1,500 feet. The local governing body had to notify residents within 1,500 feet. (Association for Retarded Citizens/Oakland County, 1982, p. 14)

As these measures were considered in the legislature, change forces exerted pressure on both sides of the issue. Advocacy and civil rights groups argued that the mentally retarded had a right not to be isolated in institutions away from society. As the House Legislative Analysis Section (1976) noted, "Every person in the state has a right to decent housing, and these persons should not be excluded from communities merely because they have handicaps" (p. 2). The same report also considered the change force of resource availability. A Department of Mental Health analysis argued that the bills would facilitate community placements, resulting in a reduction of institutional costs to the state (p. 1).

Weiner (personal communication, October 31, 1984) noted that smaller governmental units (i.e., the Association of Townships) and neighborhood associations were the change forces opposed to the bills. They argued that the legislation would affect the stability of neighborhoods and cause their decline, establish small businesses in residential areas and encroach upon the rights of local governments to control land use. Weiner (1984) also observed that social consensus was a negative change force. He said, "Part of the resistance was a fear of the retarded. The idea still prevails that they are harmful."

After eight months of debate and several substitute pieces of legislation the bills were enacted (Journal of the House of Representatives, 1976, p. 5513). Weiner (personal communication, October 31, 1984) notes that the public policy process related to this legislation still continues. He said, "Each session legislation is introduced to repeal or amend the zoning laws." He cited House Bill 5070 of 1983, which would have given a local municipality the power to recommend a site for a facility, as an example. It was referred to committee and never returned to the House.

The legislature's ability to enact such laws was also tested in the courts. The law was upheld by the State Court of Appeals in 1980 in a Macomb County case. The ruling, in part, stated:

Five mentally retarded women living with a foster parent in an environment therapeutically designed to emulate a more conventional family environment should also be considered a family and the use of the property an appropriate family residential use. The residents are more than a group of unrelated individuals sharing a common roof. ...The substitute family provided by the group home allows the residents to lead more normal and meaningful lives with the community than would be feasible were they institutionalized. (Association for Retarded Citizens/Oakland County, 1982, p. 14)

The importance of these laws, and the challenges to them, is that they established public policy related to small groups of mentally retarded people living in the community. Public policy in Michigan states that a group

home of six or less people is similar to a family home. Interestingly, this is the same concept that the earliest institutions also sought to achieve (e.g., C. T. Wilbur in Kalamazoo and H. B. Wilbur in Massachusetts).

#### Family Support Subsidy

Public Act 249 of 1983, the Family Support Subsidy Act, amended Michigan's Mental Health Code. The law provided for state funded financial subsidies to families who care for their severely impaired children at home. As Herman (1986) states:

The intent of this program is to prevent or delay out of home placements of children with educational classifications of severely mentally impaired, severely multiply impaired, or autistic impaired; and to facilitate the reunion of families whose children are in out-of-home placements. (p. 1)

The subsidy was to be paid to a parent or legal guardian on behalf of the child and would be used to meet the special needs of the family.

Representative Debbie Stabenow (personal communication, February 20, 1986), sponsor of the legislation, indicated that development of this law was a cooperative effort between a number of change forces. She said, "The effort began with a group of parents who came to me saying they wanted to keep their handicapped children at home, but this posed special problems for their families. It put a financial strain on the family

that most others do not have." Over a period of 12 months Stabenow and the parent group worked with governmental agencies and interest groups to develop ideas which ultimately became the proposed legislation.

Stabenow (1986) indicated that the Department of Mental Health and the Governor's office were involved as change forces in a unique way. She and C. Patrick Babcock, Director of Mental Health, had discussed legislative priorities early in 1983, including the Family Support Program. The Governor's proposed budget for that year included a line item for a family assistance program. Stabenow said, "Because of this cooperative planning, we actually had money in the budget before the policy passed. It is probably a first that we did not have to wait until the following session to implement the program."

The House Legislative Analysis Section (1983) described the legislation as an attempt to reverse state policy which encouraged the breakup of families. The report suggests that one argument on behalf of the bill was that Michigan policy encouraged out-of-home placements for severely mentally retarded children by neglecting the special needs of families who kept their children at home. It further states, "The bill would begin to correct the historical trend toward state funding of only the most expensive and restrictive care

for severely impaired children" (p. 2).

An argument was also offered that this legislation would save the state money, at least in the long run. Plachetka (personal communication, March 19, 1985), an aide to the House Mental Health Committee, argued that in 1983 costs at state institutions averaged \$137 per day, group homes cost between \$25 and \$70 per day, while the subsidy would cost approximately \$7 per day. She said, "Returning just one or two children to the community would pay for a number of subsidies."

The argument in the legislature (the change setting) against the bill was that the state could not afford any new programs. A tax increase had been passed to correct budget deficits and the total economic picture in the state was not positive. The House Legislative Analysis Section (1983) reported that the long-range savings attributed to the bill were probably exaggerated. It also estimated the projected costs to be higher than originally estimated. The report added, "While placements might be avoided in some of the marginal cases, the majority of families make the decision to keep a child at home based on factors other than their financial situation" (p. 3).

Other arguments against the bill came from some advocates and professionals who thought that the subsidy might take funds away from direct services. Bradley and

Agosta (1985) found a second argument from professionals. They wrote, "Some professionals were concerned about giving money to family members without the involvement of professionals to oversee the use of the funds" (p. 21).

Arguments against the legislation were overcome by an organized lobbying campaign on the part of parents. Legislators were contacted by families and asked to support the bill. Families also testified at legislative committee meetings bringing their children with them (Bradley and Agosta, 1985, p. 21). Plachetka (personal communication, March 19, 1985) concurred regarding the impact of family testimony. She said, "Given the financial climate of the State, the bill should have never passed; but there wasn't a single legislator who could vote against those kids after seeing them."

The Family Support Subsidy bill became law in December, 1983. The program became operational the following July, with families receiving the first subsidies in August, 1984.

The Department of Mental Health evaluation of the subsidy act (Herman, 1986) indicates that 27 percent more families enrolled than were expected, 19 children returned home from various types of placement and 27 were placed out of their home (pp. 37-47). Herman concludes her report by stating, "Additional efforts are now required to continue and expand available family-oriented



services and supports and to integrate all aspects of home-based care for handicapped children" (p. 47).

#### Related Legislative Action

Two other legislative actions are related to residential care of the mentally retarded in Michigan, the Mandatory Special Education Act and the Michigan Handicapper's Civil Rights Act.

Public Act 198 of 1971, Michigan's Mandatory Special Education Act, states that schools must provide special education programs and services designed to develop the maximum potential of every handicapped student (Michigan Compiled Laws Annotated, 1985, p. 270). This act provided a full range of services to children who previously had not had them, thus enabling parents to better maintain children at home.

Sharon Miller (personal communication, March 19, 1985), former deputy director within the Department of Mental Health, stated that this law had a great impact upon the mental health system. It not only provided services to mentally retarded children in the community but in institutions as well. Miller said, "All teachers were to be special education teachers and children were to receive as many services outside the hospital setting as possible." The law moved children out of institutions to go to school, and supported the idea that they could

survive outside the facility.

Campbell (1986) found in his research that parents of the mentally retarded were a prime force in getting this law passed. Local chapters of the Association for Retarded Children raised money for a legal fund to support the legislation. The Association was also preparing a class action suit to be filed against the State Department of Education in federal court claiming that mentally retarded children were being denied their right to a public education. Plans for the suit were withdrawn when parents were assured a legislative remedy.

Michigan's law was a forerunner to the federal Public Law 94-142. Under these two laws, Michigan special education students are eligible for an array of "related" services, including developmental, corrective and supportive services required to help a student benefit from educational programs. In addition, services designed to meet the unique needs of handicapped persons must be provided. These include, but are not limited to:

1. audiological, medical, psychiatric, psychological, speech and language, and educational evaluation;
2. occupational, physical, recreational, music, work, or other therapy;
3. mobility and orientation services, and special educational services provided by other non-teaching

personnel;

4. transportation;

5. services designed to assist the regular education student, including school psychological and social work services; and

6. instruction provided by special education teachers designed to assist regular education students who are homebound, hospitalized, or placed in juvenile detention facilities (Petovello & Sullivan, 1981, pp. 17-20)

Michigan's education policy mandated that schools had to work toward assisting the student to reach their full potential. By doing this, and providing a broad range of services beyond academics, Public Act 198 of 1971 allowed many children to remain at home.

Public Act 220 of 1976 (and subsequent amendments) is entitled the Michigan Handicapper's Civil Rights Act. This act became effective in March, 1977 and prohibited discrimination against handicappers in employment, housing, public accommodations, public service and education (Cooper, 1984, p. 826). Although the Special Education Code provided for educational rights of the mentally retarded, this Act assisted in securing housing and employment for individuals as they become more independent in community living.

For example, Section 102(2) of the Act provides that

an employer has a duty to accommodate a handicapper for the purposes of employment unless it can be demonstrated that this imposes an undue hardship (Ettinger, 1985, p. 831). This has allowed for modification of work areas and the use of special equipment to perform job duties.

### Summary

During the years from 1960 to 1983, a substantial number of laws were promulgated which had great impact upon residential care and treatment of mentally retarded people in Michigan. It has been shown that the development of these laws was an iterative process that took place over an extended period of time.

In considering these laws within the policy development framework used in this chapter, it can be seen that, as they move from the status element category into a change setting, they are influenced by many change forces including special interest and advocacy groups, government initiatives, resource availability, government employees, social consensus and judicial opinion. It is beyond the scope of this study to assess which change forces have the greatest impact. But, their degrees of influence on change do appear to depend on the specific issues and the change setting in which they are being considered.

### The Population

An assessment by C. Patrick Babcock (personal communication, March 25, 1985) of his first years as Director of the Department of Mental Health captures the state of the population status element between 1960 and 1983. He said,

If I were to make a criticism of the last three years it would be that we've been too fiscally oriented, and that too much of our policy has been dictated by the budget. ...Too much of our time is tied up in the fiscal side and not enough time with the programmatic or clinical side. In the long run it could hurt the place.

As one reviews the official documents of the Department from approximately 1960 on there appears to have been a move away from attention to individual client situations and concerns, to consideration of the larger population. Facility directors report on numbers and budget figures. Rarely are there individual anecdotes of progress or success. Mentally retarded people are considered as groups. Comments such as, "The total bed capacity of the facility is..." or "The county has 26 trainables that..." are common in annual reports. Perhaps one of the reasons for this was that the numbers of people being served had become so large that it was no longer feasible to respond to the individual. In 1960, eight state home and training schools cared for over 11,000 residents with 4,000 employees (Michigan Manual,

1960, pp. 273-278).

One common institutional practice in the early 1960s was the testing of drugs by pharmaceutical companies. Tests of measles vaccines, hepatitis vaccines and fluoride retention are part of the Department's administrative records. For example, a letter from the Sandoz Corporation to the Department on December 28, 1960, requests permission to test one of its new products, Mellaril, in Michigan facilities. The company assured the Department that the drug would soon be approved by the Food and Drug Administration and that they would assume all testing costs.

Throughout the 1960s and 1970s, the Department carried on an active research program at institutions, in an attempt to improve service delivery. Research occurred in such areas as motor sensory development, retardation and blindness, nutritional aspects of retardation, cancer and mongoloid children and training of the deaf-blind retardate. Much of this research was federally funded as a result of the President's Panel on Mental Retardation (DeLoach, personal communication, January 17, 1986).

One factor about institutional populations during this period is the relatively high functioning level of the people living there in the mid-1960s. The Michigan State Plan, prepared in 1966 to secure federal funding,

indicated that in 1965 approximately 12,000 people lived in state mental retardation institutions. Almost 5,000 of these people were classified as being either moderately, mildly or borderline mentally retarded. This large number of higher functioning people influenced programs of the period, which will be discussed in the next section.

Changes in the definition of the population also occurred during this period. Palloway and Payne (1975) compared the 1961 and 1973 definitions of mental retardation used by the American Association on Mental Deficiency. The 1961 definition of intelligence indicated that one standard deviation below the mean constituted retardation, while the 1973 version stipulated two standard deviations below the mean. This eliminated the level of borderline mental retardation. As Palloway and Payne note, this change resulted in a 13.6 percent decrease in the prevalence of retardation in the population, at least by definition. The 1973 revision also added the concept of deficits in adaptive behavior. This meant that intelligence was not the sole criterion for a diagnosis of retardation. One's ability to effectively live in their environment was considered (pp. 12-13). The changed definition was accepted by practitioners and as the legal definition in Michigan by the mid-1970s and continues to be used.

In 1978 Michigan's Mental Health Code (Public Act 258 of 1974) was amended by deleting the words mental retardation and substituting developmental disability. This did not change the definition of mental retardation, but rather, broadened the scope of Michigan's mental health code. The added language reads:

Developmental disability means an impairment of general intellectual functioning or adaptive behavior which meets the following criteria:

- (i) It originated before the person became 18 years of age.
- (ii) It has continued since its origination or can be expected to continue indefinitely.
- (iii) It constitutes a substantial burden to the impaired person's ability to perform normally in society.
- (iv) It is attributable to 1 or more of the following:

(A) Mental retardation, cerebral palsy, epilepsy, or autism.

(B) Any other condition of a person found to be closely related to mental retardation because it produces a similar impairment or requires treatment and services similar to those required for a person who is mentally retarded.

(C) Dyslexia resulting from a condition described in subparagraph (A) or (B). (Michigan Compiled Laws Annotated, 1980, pp. 173-174)

In 1980, the President's Committee on Mental Retardation commissioned a Gallup Poll on people's attitudes toward the mentally retarded. The results found, "Most Americans express an accepting attitude toward their fellow citizens who are retarded, but some fear and lack of confidence persists" (p. 7). At that time, 94 percent of those polled thought that only some



retarded people had to live in institutions, while only 1 percent believed that all did.

The Joint Mental Health Oversight Committee (1980), in assessing community placement in Michigan, referred to the Gallup Poll. The report indicated that although no specific data existed for Michigan alone, the Committee found a corresponding majority of neighborhoods accepted group homes with few objections (p. 45). This was a significant change from public concerns about the retarded that existed during the growth and expansion of facilities to segregate and isolate people in Michigan. It was also a change from the objections raised only a few years prior to this time when group homes were vandalized during construction and threats to providers were common occurrences.

Another indicator of the changing view of the population is found in the enactment of the Family Support Subsidy (Public Act 249 of 1983). First, families appear more willing to keep children at home and to have them recognized as part of the family, as indicated by evaluation of the program (Herman, 1986). Second, the legislation specifically mandated an evaluation of the program, that called for information about individual families. Case studies were included as a requirement of the Act--a return to the anecdotal information lost for many years due to the size of the

system.

Other changes regarding the population exist, and are directly linked to programs developed and revised during this period.

In summary, the mentally retarded population during 1960 to 1983 continued to grow in size. Its definition has also been altered by interest groups and government initiative. Most important, it moved from being considered a large, nondescript group to a more acceptable segment of society.

### The Programs

As can be observed from the laws of this period, programs for the residential care and treatment of the mentally retarded shifted between 1960 and 1983. The major source of services moved from state institutions to local communities. This section reviews some of the major service programs during this period and the change forces which influenced their modification.

### Institutions

In 1960 the Department of Mental Health had six institutions for the mentally retarded and contract services at one other. Although additional beds had been made available in the facilities, waiting lists continued to grow. A Department of Mental Health news release

dated July 5, 1962, said that the total number of children and adults awaiting placement was 1,616. This figure increased by 40 people each month (p. 1).

In 1961 the legislature attempted to pass legislation addressing the problems of overcrowding, but nothing was done. A news release from the office of Representative Joseph Kowalski (1961) indicated that the situation in state institutions was deplorable. He referred to overcrowding, staff shortages, physical danger to residents and long waiting lists. He said, "The legislature is responsible for this situation. Democrats in the House tried to get the Governor's recommendation through but were outnumbered. What the legislature has done to the Mental Health budget is an injustice to humanity" (p. 2).

Governor John Swainson addressed this issue at length in his 1962 State of the State address. He mentioned that he had visited Lapeer State Home and found a ward of 70 hyperactive and severely retarded patients under the supervision of two attendants. At times this meant that only one person was available to watch the residents. He continued to describe the program by saying,

To you who have not seen the wards crammed with battered, paint-peeling institutional beds, it is impossible, perhaps, to comprehend that one of the goals of those in charge of such over-crowded institutions as Lapeer is the forlorn hope that beds

for patients can be moved to be 18 inches apart.  
(p. 3)

Swainson (1962) urged the legislature to take action and appropriate funds for construction of space to expand the institutions by 830 beds. He also ordered the Department to expand its family care program, to provide a wider range of community service programs and to develop plans for new buildings for the severely retarded.

The Governor's order to expand family care had two barriers to overcome. First, difficulty in identifying facilities in the community caused the institutions to allow homes with as many as 30 beds. The Department of Mental Health's Program and Activities report (1960a) stated that this situation was not desirable, but was necessary because of the bed shortage (p. 5).

The second barrier was lack of cooperation and coordination of services within communities. Campbell (1986) found that in the early 1960s, staff from institutions were coming into communities and attempting to make placements. Local Department of Social Welfare staff, who worked with Adult Foster Care homes, saw this as usurping their job functions.

In addition, funding for handicapped individuals in the community (entitled Aid to the Disabled) through the Department of Social Welfare, was not available to

clients of the Department of Mental Health. In late 1961 Governor Swainson ordered the directors of the two agencies to resolve community placement problems. From this came a system known as County Referral Programs. The institution and local staff under this agreement, were to work cooperatively on placements of individuals who no longer needed the services of state institutions. The Social Welfare Department assisted in home finding and changed its rule, allowing the mentally retarded to receive Aid to the Disabled (Campbell, 1986). This program provided more alternatives to placement in state institutions and facilitated more placements into community based Adult Foster Care (AFC) homes.

Placement from institutions was slow at first. Between 1962 and 1965 only 134 patients from state home and training schools were placed through the county referral program. As many as 2400 people had been identified as eligible for the program (Department of Mental Health, 1966b, p. 23).

The House of Representatives in April, 1962, decided to establish a committee to study aid to the handicapped. The enabling resolution read, in part,

Whereas, The problems of the handicapped are a subject of great concern and deserve special legislative action; and

Whereas, There are many citizen organizations which study the problems of the handicapped; assist directly in working on these problems; and

Whereas, The Legislature should be better acquainted with the functions of such citizen organizations, their aims and programs, to correlate their programs with that of state policy in order to achieve a united program of aid to handicapped citizens of the state; now therefore be it

Resolved by the House of Representatives, That the standing committee on aid to handicapped be appointed by the Speaker of the House, to function in the interim now and between the 1962 and 1963 Legislative Sessions, to meet with private citizens and organizations to hear and study their problems, and to report its findings and recommendations to the 1963 Legislature. (Journal of the House of Representatives, 1962, p. 1291)

Citizen organizations apparently had sufficient influence to cause the legislature to gather additional information on the subject.

The community placement program developed after being placed in the Executive change setting, with the change forces of waiting lists, governmental initiative, resource allocation and legislative attention, focused upon it. Although slight modifications took place from time to time, the program remained basically the same throughout this era.

In the Fall of 1961 a survey conducted by the Department found that 66 percent of the parents with children on institution waiting lists wanted their children admitted immediately or as soon as possible. Another 15 percent wanted their children to stay at home for the near future. Only 6.5 percent of the families surveyed did not want admission. Twelve percent of those

on the list had died, moved or lost contact with the institution (Department of Mental Health, 1962b, pp. 1-3).

These survey results show that while the Department was beginning to talk about administratively changing its system, many constituents were still desirous of placements in state facilities. This was confirmed by Rita Charron (1986), a leader in the Michigan Association for Retarded Children during the 1960s. She said, "Our goal in the early days was not to close institutions. It was to improve them and make them an acceptable place for our children." Parents, in the beginning of the period, were not a strong change force influencing the change to a community service system.

Shifts in the Department's view of institutions could also be seen in their documents. A 1962 summary report titled "An Appraisal of Michigan's Mental Health Program" stated that the state hospital was no longer the only instrument for services needed by the mentally retarded, community services also needed to be expanded. The report added, "In recent years clearly defined evidence has developed to indicate that an adequate total approach to the mental health problem necessitates a complex of services beyond the state hospital, closely allied to communities" (p. 10). At the conclusion of the document, prepared for the State's 125th anniversary, the

diminishing institutional role is mentioned. It states, "Somewhere in the future the state hospital as we know it today will cease to exist. The massive, isolated custodial hospital is a product of that period when hopelessness, incurability, confinement and isolation were the dominating concepts" (Department of Mental Health, 1962d, p. 30).

#### Movement Toward the Community - The 1960s

In a series of news releases in early 1963 the Department attempted to foster the idea of services in local communities. For example, on February 26, 1963, a news release reported the organizational meeting of the first joint community mental health services board. Representatives from Ingham, Clinton, Eaton and Livingston Counties gathered to plan local mental health services. Although Ingham county had had a child guidance clinic since 1938, and a mental health center since 1953 this was an effort to coordinate services for the entire area. Funding of \$59,000 in local money and \$49,000 in state money were used to develop local programs.

In an April 24, 1963 release titled "Overcrowding Continues for the Retarded," the department explained that its inability to provide enough beds at institutions was its most pressing problem. However, alternatives



were being explored. The release added, "Today there is a shift toward maintaining these children in the family, with the supplement of community programs of a day-care or short term nature" (p. 1).

The release went on to say that, at its new center for the mentally retarded at Plymouth, the department was attempting to make arrangements and plans for home placement before the patient was admitted. Gwen Andrew, a Department administrator, was quoted as saying, "While institutionalization of retarded children is now standard practice, there appears to be a question as to the effectiveness of this plan and a search for better and more effective programs is currently under way" (p. 2).

One of the major forces that assisted the Department in changing its philosophy was growth of special education programs. In a report for the Department of Public Instruction, Harris (1963) found that almost 23,000 students were enrolled in local special education classes state-wide. This number had increased from only 6,000 students ten years earlier (p. 7).

The report indicated that more school districts were establishing programs and that special millage elections had been held in 43 counties to support them. The report concluded that there was a positive trend toward acceptance and community responsibility for mentally handicapped children. It stated, "Service agencies, plus

community resources are effectively planning in cooperation with public schools a realistic approach to the needs of mentally handicapped youth in many Michigan communities" (Harris, 1963, p. 6).

Harris also recommended that there was a need for a broader range of services including post-school special education programs, parent counseling, special training for teachers, services for adult retarded people and services to the more severely handicapped student.

The change in residential care philosophy also influenced the legislature. In 1962, House Bill 103 proposed construction of a new 1000 bed facility in west central Michigan. As a result of various Senate and House study committees the facility was scaled down to 250 beds. In 1964 both houses of the legislature received reports on community mental health services. The general recommendations in the Senate report read:

1. Flexibility for local initiative and administrative arrangements between state and local units of government must be maintained.

2. State mental health services in local communities should not be expanded by the state, but the state should encourage local communities to adopt, expand and develop local services under the Community Mental Health Services Act.

3. A simple uniform record system covering services rendered in community mental health programs should be adopted by the state. This record system should be developed jointly by state and local professional authorities.

4. The state's efforts should be in the

direction of helping state hospitals to develop Community Mental Health Services.

5. State hospitals should consider adopting the system of regionalized wards wherein all patients from a particular county or geographic area would be together in the same physical area of the hospital.

6. No large new facility should be built for the mentally retarded. Emphasis should be placed upon small centers in metropolitan areas on a demonstration basis. These centers would serve more retarded on a day care, consultation and diagnostic basis than they would inpatient. (Senate approval of planning for a 250-bed home and training school in the Muskegon area is a good example of this.)

7. Waiting lists should be re-evaluated with the goal of providing some treatment service to patients within 30 days. (Senate Journal, 1964, p. 1495)

In 1964 the Planning Division of the Department created a Task Force on Mental Retardation. This was one of several advisory groups established in response to federal legislation (Public Law 88-164, the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963) which made funds available for mental health services. Sellin (1979) notes that this legislation was an outgrowth of the President's Panel on Mental Retardation and provided a major impetus to interagency service efforts. He says, "Between 1963 and 1966 was a period of significant activity for the states to develop their own equivalent to the President's Panel Report" (p. 217). The group, which later changed its name to the Mental Retardation

Planning Committee, brought together representatives from parent groups, medical services, universities and other State agencies. A review of the committee's meeting minutes reveals that its purpose was to assist in developing an overall plan and to make recommendations concerning mental retardation services in Michigan. Areas of concentration were welfare, employment, education, rehabilitation, prevention and research (Task Force on Mental Retardation, 1964). The value of this group was that it brought together people to plan services, especially non-institution based.

Planning groups took many different forms and titles during the decade. In 1966 there was the mental retardation planning committee, five mental retardation task forces, a task force on mental health statutes, an advisory council on facilities and an advisory group for planning mental retardation services. These groups had a total of 126 participants from a cross section of the population. In July, 1966, recommendations from these groups were brought together in a document titled, A Plan to Combat Mental Retardation in Michigan (Department of Mental Health, 1966b). The plan included hundreds of recommendations for services to the mentally retarded. The report's concluding statement read:

To achieve this level of progress will involve the effort of many people and many agencies. It will require a commitment on their part of knowledge and

a commitment of time and energy to act upon that knowledge. The degree to which all people interested in the welfare of the mentally retarded are willing to mobilize Michigan's resources is the degree to which the interests of the mentally retarded will be served. (p. 28)

The involvement of so many people in planning functions had a long-term impact on service development in Michigan. As Sellin et al. (1974) noted, the value of interagency cooperation came primarily from its benefit to agencies in service delivery to clients. But Sellin et al. also stated, "Service development and delivery is more than extensive consultation from state levels. Community personnel are not necessarily requesting more funds as much as greater flexibility in their allocation and administration" (p. 27). Administrative control would continue to be an issue in the development of community services throughout this period.

One outgrowth of these planning groups was the State Interagency Cadre on Mental Retardation. The Cadre was federally funded and organized to serve as a liaison between the State Interagency Coordinating Committee on Mental Retardation and 19 regional committees. The five staff consultants also served as advisors to their individual departments regarding service needs of the mentally retarded. The departments represented were Education, Public Health, Social Services, Vocational Rehabilitation and Mental Health.

The first year State Interagency Cadre on Mental Retardation Report (1967) notes that the a group was unique to Michigan and had produced a better understanding of the needs of the retarded, at least between participants. It also noted that establishing and running interagency services was a very difficult task. The report states, "Conceptually, the idea appears sound, but it is another matter to implement it and obtain maximum functional operation. Interdisciplinary functioning requires respect for another's capacity to contribute, and it requires sharing of information and compromise" (p. 19).

The Cadre reported that a number of interagency services for the mentally retarded and their families had been established. These included:

1. Vocational and adult activity programs.
2. Coordinated information and referral services.
3. Diagnostic and evaluation services.
4. Construction and renovation of facilities to provide programs.
5. Interagency workshops to train staff. (State Interagency Cadre on Mental Retardation, 1967, p. 1)

The Cadre, advisory councils and task forces established in Michigan beginning in the 1960s provided a change setting to broaden the scope of services needed by the mentally retarded. Because of these groups, care and

treatment of the mentally retarded was no longer the sole domain of the Department of Mental Health. It had moved beyond the hospitals and begun to take on many forms.

One service designed to slow the growing facility waiting lists, was establishment by the department of day care services. The more severely retarded child was excluded from school programs in the mid-1960s and, in order to receive services, was placed on an institution waiting list.

The first center opened in Port Huron in 1964. Within two years there were 12 centers serving 175 school age and 33 preschool age children, with I.Q.s of 30 or below. Admission priority was given to children on institution waiting lists and offered to parents as either a temporary or indefinite solution to waiting for placement. (Waiting lists for four state institutions exceeded 1,700.) Children not on waiting lists were also admitted to these programs, which according to the Department, operated at full capacity (Department of Mental Health, 1966a, pp. 33-34).

In addition to the State funded day centers there were also 45 other programs operated by parent groups. In 1965 these programs reported serving approximately 1,400 children, seven times the number served by state funded programs (Department of Mental Health, 1966a, p. 51).

For individuals beyond school age various training, sheltered workshop and activity center programs were also developed in the 1960s. The best funded service appears to have been the Training Opportunity and Placement (TOPS) program conducted in state institutions between 1965 and 1968. Funded by a grant from the United States Department of Labor, TOPS offered job training and placement in work situations both on institution grounds and in communities surrounding facilities. The Department reported that over 2,600 residents were involved in this program. As a result of the project, a number of people were placed in Department funded half-way houses and thus given opportunity to exit the institution.

In contrast, most community workshop programs were poorly funded, if at all. For example, the Community Opportunity Center in Livonia, Michigan, served 13 mentally retarded adults. The program was conducted in space donated by the local school district and funded by the Livonia Jaycees. Funds were sufficient to buy supplies, but not to hire staff. The program was operated by 150 volunteers who each came one half day per month. Wendell Smith (1965), director of the board, requested support from the Department of Mental Health and Governor Romney but was never granted funds. DeLoach (personal communication, January 17, 1986) verified that



this was a common situation with community programs at the time. This is also why only 23 workshops existed in 1965, serving 550 mentally retarded people.

Although various small community programs were beginning to develop, the greatest source for 24 hour residential care continued to be the 10 state institutions. In 1965 these facilities had a total resident population of 12,275. The facilities reported a "book census" of 14,080 people, meaning that they claimed to be supervising almost 2,000 additional residents on leave or placement status in the community. Six of the 10 institutions were operating beyond planned capacity; five had more than 1000 residents. The largest facility was Lapeer with over 3,700 residents (Department of Mental Health, 1966a, p. 17).

The State Plan also pointed out that over 2500 residents were classified as mild or borderline retarded and another 2300 people were classified as moderately retarded. The report stated, "It is generally acknowledged that placement in large public institutions has been over used in caring for the retarded, largely because satisfactory alternative solutions have not been available" (Department of Mental Health, 1966a, p. 17). The report went on to say that 2400 people had been identified who could live and work outside the institution if adequate vocational assignments and proper

residential accommodations could be made available.

The alternatives were community-based living facilities. It was suggested that these facilities be placed in all of the state's urban centers where necessary support services were available or could be developed. Department of Mental Health (1966a) planners envisioned these facilities serving between 25 and 50 people, yet remaining eligible for federal funds, just as the larger facilities were (p. 23). The concept was to build mini-institutions throughout the state.

Projections of the population in need of institution placement over the ten year period 1965 to 1975 also indicate the Department's program emphasis. Based on the fact that community support services were limited, and that the general state population would continue to grow, it was estimated that over 16,000 institution beds would be needed by 1975. Planners recognized that if services such as counseling and day programs were readily available, this number could be lowered by 4,000 people. It was stated, "This second set of projections suggests that if sufficient program development in communities can be accomplished to make appropriate community placements possible, needs for institutional care should be stabilized somewhere close to present institutional capacity" (Department of Mental Health, 1966a, p. 19). In actuality the population of state facilities in 1975

was approximately 6,500 people (see Figure 4).

In November, 1969, the Department published a report which described programs and services for the mentally retarded as Michigan prepared to enter the 1970s. A number of changes in the residential care system were noted. Commitments which had averaged approximately 1,000 per year for the previous ten years, dropped 30 percent, to 623 in 1969. Similarly, discharges which had averaged 300 for the previous ten year period rose to 561. The report added, "For several years the resident census has remained at approximately the same level (12,000 to 12,500), while the number of retarded receiving community based programs has steadily increased" (Department of Mental Health, 1969a p. 23).

Several factors were credited with establishing these new trends. They included:

1. Extension of community day training centers for severely retarded children.
2. Development of community activity centers for adults.
3. Program advances at state home and training schools, including expansion of out-patient services.
4. Collaborative efforts of Departments of Mental Health and Education, resulting in extension of pre-vocational and vocational habilitative services.
5. Joint action of Departments of Mental Health and

Social Services to revise and up-date procedures for county referral services to institutionalized mentally retarded people.

6. Increased public school programs for the retarded, with enrollments exceeding 50,000 children.

7. Continued growth of vocational counseling and placement services for educable retarded in school programs. (Department of Mental Health, 1969a, p. 23)

Institution programs during this period also became more specialized. Existing facilities began to develop activity programs for mentally retarded people with multiple handicaps, including the blind, deaf and emotionally disturbed. In June, 1969 the Muskegon Regional Mental Retardation Center opened with a maximum capacity of 254 residents. The center served a six county area and had begun to develop a community oriented service. Not only were services offered to residents, but also to the mentally retarded living with their families in the service area (Department of Mental Health, 1969, pp. 24-25). This concept would ultimately conflict with the community mental health programs concept. Authority to operate local programs was becoming an issue.

In 1969, five additional construction projects similar to the Muskegon center were approved. These centers were expected to accommodate 1,800 people and

make possible the closing of Fort Custer, which had been occupied "temporarily" since 1956 (Department of Mental Health, 1969, p. 25).

These construction plans were supported by the legislature because of concerns that many existing state facilities were inadequate. In March, 1969, 31 Representatives introduced House Concurrent Resolution 84. It read, in part:

A concurrent resolution of legislative intent to, somehow, some way, blast Michigan's mental hospital physical plan at least somewhat into the Twentieth Century.

Whereas, From a humane standpoint they are woefully short of being proper places for any human being even to visit (you ought to visit one and find out!), from a medical standpoint it would be cheaper to tear them down than to fix them up; and

Whereas, Even the most architecturally inept among us need no expert advice to recognize that Nineteenth Century hospital buildings have been anachronism for the last 69 years, and that a stone fort does not a hospital make; now therefore be it

Resolved by the House of Representatives (the Senate concurring), That the Department of Mental Health is authorized, encouraged, and if necessary, begged to forthwith obliterate from the face of the earth any and all mental hospital structures in its responsibility that were built before January 1, 1900. (Journal of the House of Representatives of Representatives, 1969, p. 647)

Although the resolution died in committee, it pointed out the sentiments of some toward facilities in Michigan.

One final observation must be made from the Department of Mental Health (1969) report. A section on community services states that \$10.9 million was

allocated to the state's 33 Community Mental Health Boards in budget year 1968-69. This was for all services to both the mentally ill and mentally retarded people served (pp. 16-17). By comparison, the 10 state hospitals for the mentally retarded, exclusive of central office costs, received a combined budget of \$67.3 million (Michigan Manual, 1972, pp. 270-279).

This difference highlights the dissonance that existed in the Department between the conceptualization of community services and funding priority. For example, Dr. William Anderson (1969), Department Director, told a gathering of psychiatric hospital administrators that funding could not always reach the hospital ward level because it had to be allocated elsewhere. He said, "Much of the new money goes into clinic activities, Act 54, placement programs, new programs for children and employee benefits" (p. 14).

Such commentary by state level administrators, and establishment of regional centers such as the one in Muskegon, served to foster a schism between institution and the community systems. As previously discussed in relation to interagency planning, the question of administrative authority continued to be an issue that affected program development throughout this period.

What appears to have existed during this period were competing governmental initiatives as change forces.

Both state and local administrators were attempting to impact upon the changing program status element. This process continued over an extended number of years.

#### Program Change in the 1970s

The Department opened three additional institutions in the 1970s (Northville Residential Training Center, 1972; Macomb-Oakland Regional Center, 1976; and Southgate Regional Center, 1977). It also closed one (Fort Custer, 1972). The Macomb-Oakland and Southgate centers were intended to be small and were constructed as alternatives to the large facilities that existed elsewhere in the state (Department of Mental Health, 1978, pp. 5 & 12).

Hunt (1983) studied the development and eventual closure in 1983 of Northville Residential Training Center. The facility was established on the grounds of the Northville Regional Psychiatric Hospital in four unused buildings. It was opened because Fort Custer was declared a fire hazard and its residents had to be moved. The capacity of the facility was 180 people (Hunt, 1983, pp. 3-4).

Hunt (1983) described the arrival of the first residents. He said, "Some had been tied to their seats and were exhausted. Black markers had been used to write each resident's name on one arm and a case number on the other. Clothes and what worldly possessions they had

were crammed into plastic trash bags" (p. 4). From this beginning, staff worked to develop programs suited to the residents. Some basic guidelines were developed by hospital administrators which included:

1. No resident would be in diapers.
2. Every resident would have a day program to attend.
3. Professional staff offices would be located in the resident buildings and not the administration building.
4. Equipment to foster the education of residents would be purchased and used.

Hunt (1983) stated that while these ideas were commonplace in the 1980s, they were programmatic firsts for state operated facilities in the early 1970s (p. 6).

Northville Center is an example of the changing form of residential care and treatment for the mentally retarded in Michigan. The 1970s were a cross-road between the old state system and the new community system. For instance, Northville was designed as a small facility, but it was housed on the grounds of a larger state institution for the mentally ill. It began as a facility to take resident transfers from another institution, but became very active in the placement of residents into community homes. It took residents that had received basic custodial care for years and developed



individualized, training programs for them. Finally, it closed as the state conformed to new regulations and down-sized all institution facilities. It had been established as a temporary institution and fulfilled its purpose.

#### Federal Funding Impacts

Federal funding of residential facilities in the 1970s occurred primarily through the Medicaid program. In 1971 Congress passed a series of amendments to the Social Security Act called Medicaid or Title XIX amendments. One element of Title XIX was a program called Intermediate Care Facilities for the Mentally Retarded (ICF/MR). The Joint Mental Health Oversight Committee report (1980) notes, "Congress developed this program in order to provide States with a Federal financial participation incentive for upgrading and improving the quality of care of institutionalized mentally retarded persons" (p. 61). States that wished to enter the program were required to submit a plan to achieve compliance with federal standards of care.

Michigan initially used this program to renovate its state institutions to meet federal physical plant standards. Campbell (1986) found that millions of dollars were spent to remodel facilities, giving residents smaller, more modern living units. In

addition, in order to be certified, facilities had to meet specified staffing and program standards. Campbell (1986) said, "For the first time the concept of individualized plans was put into practice. If plans were not carried out there was the threat of losing great amounts of money."

According to Ben Censoni (personal communication, March 4, 1985), Director of the Department's Office of Community Residential Services, Michigan began to implement the program in 1975, although federal regulations were not finalized until June, 1977. He stated, "The regulations are very institutional based. We accumulate a bill of charges for people who qualify and we bill Medicaid for services provided."

The problem, Censoni (personal communication, March 4, 1985) pointed out was that, although a new funding source was available to institutions, it quickly became apparent that when a person left the facility, the money stopped. This meant a loss of income to the facility and an additional cost to the state in providing for community placement. This actually created a disincentive to move people out of institutions.

The solution was to develop a small group home component under the ICF-MR funding mechanism. Censoni (personal communication, March 4, 1985) said, "Initially what the Feds had in mind was that instead of having huge

buildings on campuses, they would have a series of smaller buildings." Michigan argued that regulations did not preclude small community homes that were not on campus, but rather on scattered sites throughout the communities. What developed was Alternative Intermediate Services for the Mentally Retarded (AIS-MR)--an alternative to Medicaid funded care and services in institutions.

Because of requirements for smaller living units and the development of the AIS home model, many people moved from large state facilities to small group homes. By the end of 1983 the Department of Mental Health (1984) reported that there were 200 Alternative Intermediate homes in the state housing almost 1100 people. The report stated, "Only a few years ago, it would not have been possible to provide this level of programming in the community. Now with federal financial support and the increasing availability of community services, it is both programmatically and economically feasible to develop and operate these homes" (p. 2)

Resource availability (federal funds and community programs) coupled with government initiatives (Title XIX rules for smaller facilities) became a change force to develop community residential housing. Yet, the ICF/MR program is only one example of development of a community system of residential care. AIS houses could not

accommodate all of the people that had to be moved in order to meet institution size requirements under Title XIX. Therefore the rules caused other types of housing development to take place in the community.

Community Mental Health Boards were also growing in size and capacity and beginning to request implementation of Section 116 of the 1974 Mental Health Code. In describing the powers and duties of the Department, parts of this section stated,

(e) (ii) It shall be the objective of the department to shift from the state to a county the primary responsibility for the direct delivery of public mental health services whenever such county shall have demonstrated a willingness and capacity to provide an adequate and appropriate system of mental health services for the citizens of such county.

(g) It shall endeavor to develop and establish arrangements and procedures for the effective coordination and integration of all public mental health services, and for effective cooperation between public and nonpublic services, for the purpose of providing a unified system of statewide mental health care. (State of Michigan, Public Act 258, 1974, p. 913)

Many Boards within the state began to take on the primary responsibility for service delivery, including residential programs.

William Allen (personal communication, February 21, 1985), Community Mental Health Board director stated that for a number of years the only funds available from the state for program expansion were community placement funds or funds to move people from state facilities to

community group homes. Allen stated that his organization developed services that were built around a continuum of care. He said, "That was a major change in our organization that occurred around 1976 and progressed rapidly between 1976 and 1980. ...I think a major change came about because of the planned community effort, and it needed to move people to make it work."

#### Resident Rights

At about the same time rules related to federal funding for residential care and treatment of the mentally retarded in Michigan began to have an impact on services, rules related to the rights of residents began to be enforced.

Chapter 7 of the 1974 Mental Health Code is titled "Rights of Recipients of Mental Health Services." The chapter goes beyond defining basic constitutional and civil rights to include many special provisions. Section 704(3) states, "The provisions of this chapter shall be construed to protect and promote the basic human dignity to which a recipient of services is entitled" (State of Michigan, Public Act 258, 1974, p. 961). The rights of clients in the State's mental health system include: physical and medical examinations, individualized plans of services, information regarding status and progress, consent for surgery and chemotherapy, freedom from abuse,

communication with others, personal property, payment for labor performed, education and training, freedom from seclusion and restraint, and freedom to move about without unnecessary restriction. In implementing this chapter, the Department was also expected to establish a system to receive reports of and investigate violations of the rights guaranteed by the chapter (Michigan Compiled Laws Annotated, 1980, pp. 214-239).

Campbell (1986) found that the immediate effect of this chapter was that institutions were mandated to provide treatment and programs. Custodial care had become illegal. Community programs also had to adhere to the standards set in the chapter. Thus Chapter 7 of Public Act 258 of 1974 influenced services for a great many people state-wide.

Stehman (personal communication, February 27, 1985) and Tarr (personal communication, February 13, 1985) observed that the chapter had another impact on residential services. It took several years to implement this section and to establish an Office of Recipient Rights. In late 1977 and early 1978 Rights Officers in state institutions were documenting large numbers of complaints. Tarr said, "It was relatively new so they were documenting everything and they had tons of material." The documentation was then used by advocates.

At the state institutions for the mentally retarded

the Association for Retarded Citizens and individual parents began paying attention to the documentation performed by the Rights Officers. They continued to complain to the Department about allegations of abuse, but this time using documentation available through the Recipient Rights Office. The Association felt that little was being done to correct the situation and decided to take action (Charron, 1986).

On February 19, 1978, a headline appeared on the front page of the Detroit Free Press that stated, "Children Tortured; State Center Covers Up." The story said that after a review of hundreds of documents, Free Press reporters found multiple cases of neglect, physical and sexual abuse of residents at Plymouth State Home and Training School. The report continued, "Further, the administration has covered up and refused to take the necessary steps to stop the abuse a Free Press investigation shows" (Magnuson and Watson, 1978, p. A1).

Both the Director at Plymouth Center and his supervisor, the Department's Regional Director, were implicated by the newspaper as knowing about patient abuse, yet doing nothing about it. Stehman (personal communication, February 27, 1985) said that reporters told him they talked to various administrators and no one acted; including the Director, Donald Smith. Stehman said, "He probably let it sit for too long."

A future director of the Department of Mental Health, who was administering another state department at the time, observed that at the top level Governor Milliken was caught by surprise. In cabinet meetings there had been indications of problems in mental health but the implications were that they were not severe. The administrator said, "I think the worst thing happened to him that could happen to any Governor or political person, that is, that his appointees were not being candid."

On February 21, 1978 the Michigan Association for Retarded Citizens, the Plymouth Association for Retarded Citizens and 12 individuals brought suit against officials of the Michigan Department of Mental Health in United States District Court. The suit charged abuse of residents, mismanagement of the institution and misdirection of the Department of Mental Health in the care and treatment of mentally retarded persons (Michigan Association for Retarded Citizens v. Smith, 1979, p. 991).

On August 29, 1979, Judge Charles Joiner issued a Memorandum Opinion and Decree that was agreed to by all parties in the case. The decree said that mentally retarded individuals should live in the community instead of the institution. Paragraph 7 states,

Based upon the record and consideration of



submissions by the parties and the Monitoring Committee established by this Court in conjunction with this case, the Decree may be entered by the Court and is consented to by the parties for the purpose of establishing a commitment to the development of a comprehensive system of appropriate, less restrictive treatment, training and support services for each member of the Plaintiff class. All mentally retarded individuals can and should live in the more normalized environment of the community and do not require institutionalization, given the development of necessary habilitation and support services in the community. (Michigan Association for Retarded Citizens v. Smith, 1979, p. 993)

The decision also banned further admissions to the center, stipulated staff to client ratios, defined acceptable treatment and ordered the development of a system to place residents into the community. The center's population was to be reduced from 602 to no more than 100 within three and one-half years. In 1981 the decree was modified to say that all residents would be placed into community living situations (Association for Retarded Citizens/Michigan, 1984, p. 3).

The court established principles for creating and maintaining suitable community placement. The major concepts were:

1. Residential environments were to be the least restrictive and the most normal settings appropriate to each resident.
2. Day programs were to be provided at a place geographically separate from residences.
3. Management had to be available to coordinate,

administer, monitor and evaluate all aspects of a person's life.

4. Client services were to be planned at least annually, based upon individualized evaluations.

5. No one could be placed in a house having more than eight beds.

6. Placement was not to be based on a person's ability to pay.

7. Guardians and families were to be involved in placement decisions.

A court "Master" was appointed to oversee implementation of the plan and the Department of Mental Health agreed to provide funds to carry out the order (Michigan Association for Retarded Citizens v. Smith, 1979, pp. 993-1000).

Weiner (personal communication, October 31, 1984) noted that the Plymouth suit was a watershed event for Michigan's placement program. Because of it the Governor called for an investigation of institutions and community placement was thoroughly studied by a joint legislative committee. Weiner said, "What it did was cause the Legislature to become educated about placement." It also heightened the concern among lawmakers that if they did not take action, the Federal courts would. Weiner added, "The idea of a federal judge setting standards for a state program and dictating that they would be funded and

carried out really upset some people."

Censoni (personal communication, March 4, 1985) indicated that incidents at Plymouth caused massive changes in the entire system. First, it caused the Department and Community Mental Health to set standards for community placement, instead of simply letting the system drive itself. Second, it showed that the vast majority of people, regardless of the severity of their handicapping condition or negative behaviors, could be cared for in the community--they did not need an institution. He said, "If we were to accomplish everywhere in the State what we accomplished at Plymouth, we would be down to 300 people." In Censoni's opinion, most of the institutional facilities in the state could be closed.

Babcock (1984) in a speech to a Community Mental Health Board said, "Four years ago a decision was made to re-shape the public mental health system. In that time we have closed down four institutions for the mentally retarded and three large nursing homes." He went on to state that in 1974, 65 percent of the Department's budget for the mentally retarded was going to institutions. In 1984, only 38 percent went to institutional facilities for the mentally retarded.

Braddock, Hemp and Howes (1985), who have performed extensive national research on expenditures for programs

serving the mentally retarded, indicate that Michigan's shift is as dramatic as Babcock stated. In 1977 the state was spending \$117 million on institutions for the mentally retarded, but only \$14.8 for community programs. By 1980 community funding had risen to \$40.9 million and almost doubled (to \$78.7 million) by 1981. In 1984 it doubled again to \$164 million.

Braddock, Hemp and Howes (1985) state, "In the span of only five years, Michigan had moved from a laggard's position to one of national leadership. The eight year gain from \$14.8 million to \$164 million was a tenfold increase in community services funding" (p. 25). At the same time funding for state institutions dropped from \$156.2 million in 1979 to \$133.2 million in 1984. If these figures are adjusted to 1977 dollar values, the reduction is 42 percent (p. 25).

Figure 3 graphically depicts this shift in Michigan's funding for institution and community programs, both in real dollars and 1977 adjusted dollars. The solid bars show the growth of community service funds, while the hash-marked bars show the decline of institution funds (Braddock, Hemp & Howes, 1984, p. 423).

From 1972 to 1984, Michigan closed five institutions for the mentally retarded. This was more than any other state. With the exception of the Fort Custer facility, the majority of residents were placed in small, community

group homes. The closures were as follows (with date and number of residents in parentheses): Fort Custer (1972, 1000); Alpine (1981, 200); Hillcrest (1982, 350); Northville (1983, 180); and Plymouth (1984, 837). (Braddock & Heller, 1984, p. 5).

One additional perspective on the change forces impacting on the changed program status element is provided by State Representative Debbie Stabenow (personal communication, February 20, 1985). Her contention was that the shifts that took place in 1980 and 1981 were strongly related to economic resources. She says, "It was mainly legislated through the budget. The shift in policy happened because the economic situation of the state caused it to happen more quickly than it otherwise would have." Community placement was viewed as a less costly alternative to institutions, and way of saving funds. Because of this, Stabenow contended that revenues were not always adequate for development of quality community placement programs.

Throughout the 1970s and into the 1980s government initiatives, resource availability, interest group actions and judicial opinions combined to act as change forces on residential care programs for mentally retarded people in Michigan. However, one should not conclude that changes in the program status elements described solved all of the problems related to caring for the

mentally retarded in the State.

An audit of treatment provided at institutions and selected types of community placement homes between 1978 and 1983 by the Office of the Auditor General concluded that revisions were still needed in the State's system of care (Pinkelman, 1984). The audit attempted to ascertain the extent of client developmental growth achieved from programs and services provided at institutions and community placement settings. The report states, "As our review progressed, we found that full attainment of this objective was limited because of the lack of documentation available to evaluate outcome" (p. 2). Recommendations were that the Department of Mental Health develop a standardized treatment outcome evaluation system, residence entry and exit criteria, criteria for defining and determining the least restrictive environment and a uniform record keeping system.

One problem in providing this type of information on a state-wide basis was that the residential care system in Michigan had become decentralized. Babcock (personal communication, November 11, 1984) said, "We presently have no uniform services across the state. There are too many Community Mental Health Boards, each operating many, many diverse programs. This is an issue we must attend to in the coming year."

In summary, during the 1960 to 1983 period changes

in residential care and treatment programs for the mentally retarded were of a greater number and magnitude. State programs changed from an emphasis on large institution care, to community care, to an emphasis on family care (at least for children). The residential program status elements were changed by multiple change forces, including governmental initiatives, interest group intervention, social attitudes, resource availability and judicial opinion. Changes took place in both the executive and legislative settings.

These revised residential program status elements will inevitably cycle back into the review process. Over time different change forces will impact upon them and new programs will continue to develop.

#### Summary

Between 1960 and 1983, many significant changes occurred in Michigan's system of residential care and treatment for people with mental retardation. At the beginning of the period more people were residents in state institutions than at any other time in the history of the state. Twenty-three years later populations in state institutions had been drastically reduced. Indications were that the downward trend would continue.

Large state institutions had been replaced by various types of smaller group homes scattered throughout

the state. Support services such as training programs, medical care and recreational activities previously provided at the institution, were now the responsibility of local communities, not the State of Michigan. The once large state bureaucracy for the care and treatment of the retarded had been decentralized and dispersed to the state's 83 counties.

Using a framework suggested by the Council of State Governments this chapter reviewed significant changes in the laws, population and programs related to residential services for the mentally retarded in Michigan. The framework took existing factors (labelled status elements) and examined the sources of pressure which impacted upon them (change forces) to bring about policy changes.

The three status elements examined were laws, population definitions and programs. These were selected because they represented the mechanisms to define (law) and implement (programs) public policy in relation to the people (population) under consideration. Specific attention was paid to the change forces of governmental initiatives, interest group actions, social consensus, resource availability and judicial opinion.

The laws of the early 1960s were influenced by parent groups like the Association for Retarded Children who initially worked to improve conditions in state



facilities. Both the legislative and executive branches were sympathetic to these concerns, and legislation related to improved care and prevention of retardation was passed.

The issue that created the greatest debate, and certainly the most extended, was that of providing services for the retarded in the community. Legislative resolutions and study commissions flourished. Arguments for and against a centralized system of service provision lasted for the greater part of two decades. The primary issue was, who should have the authority to develop, administer and modify services, the state mental health department or local agencies. Through Public Acts 54 of 1963 and 258 of 1974 the legislature, influenced by many interest groups, government officials and resource availability, established community programs and services. All of this took place over an extended period of time, with numerous variations and amendments to the policies.

In the 1970s laws relating to the rights of people who were mentally retarded were passed. Amendments to the state's zoning codes were written which prohibiting local municipalities from excluding small group homes from residential neighborhoods. The right to special education services was expanded by the Mandatory Special Education Act. The Michigan Handicappers' Civil Rights

Act extended rights to people in the work place.

Finally in 1983 the Family Support Subsidy Act was passed by the legislature providing cash payments to families with severely handicapped children. Payments are designed to assist the family in meeting a child's special needs and therefore enable the child to remain at home as part of the family unit.

Laws of this period focused on moving the center of residential care away from large, isolated state hospitals to local communities -- even back to a person's own home. This change, it has been shown, was influenced by multiple change forces which had varying degrees of influence depending upon the specific issues and the change setting in which they were considered.

The second status element, the population, was seemingly a forgotten entity in the early 1960s. The individual was lost in the large numbers of people housed in huge institutions. There was also a large number of relatively high functioning people living in state hospitals. As the period closed the higher functioning and moderately impaired individuals were placed into community homes. Those with severe medical and behavioral problems remained in state institutions.

Social attitudes also seemed to change during this period. In the 1980s, although scattered incidents existed, there was little resistance to the establishment

of group homes in communities around the state. The impact of altered zoning laws and court cases in favor of the mentally retarded may have been change forces influencing this factor.

At the close of the period, public focus was turning to multiply and severely handicapped people and how to best care for them in the community. This was the group that, twenty-three years earlier, could only be cared for in an institution because of the lack of other facilities and community resources. Changes in the laws and programs, also brought about a change in perspective regarding the population.

The program status element went through the greatest change. The 1960s began with residential programs primarily provided by institutions. Facilities were understaffed and overcrowded. To alleviate these situations, facilities developed small community placement programs. But, families continued to request institutional admissions at a greater rate than space was available because few alternatives existed elsewhere.

As special education programs developed, and began to include a wider range of children, more families were able to keep their children at home. In addition, the mental health system began to develop day programs for both children and adults.

In 1966 a Plan to Combat Mental Retardation in

Michigan (Department of Mental Health, 1966b) was written. It called for a sweeping approach to addressing mental retardation in the state. Numerous public agencies and interest groups became involved in creating local services and programs for the mentally retarded.

In the 1970s the Department of Mental Health began to consider alternatives to large, 1000 plus bed institutions. Plans for smaller (250 bed) facilities were developed at the urging of the legislature and advocacy groups. Community homes and accompanying support services were also being developed.

Federal funding, which had assisted many programs earlier in this period, funded major residential remodeling and construction projects in the late 1960s and early 1970s. Because of Medicaid regulations for funding institutions had to decrease their size and provide individualized programming. Using this money, Michigan also built specialized small group homes for more severely handicapped people.

By the late 1970s enforcement of provisions of Michigan's Mental Health Code, which called for a shift from a state program to a community program, was also taking place. In the 1980s Michigan greatly increased financing to communities, while decreasing institution funding. During this period the state closed five institutions for the mentally retarded.

In 1979 a consent decree issued in federal court to settle a law suit brought against the department, set standards for community placement and ordered that it take place for all residents of one of Michigan's institutions.

Between 1960 and 1983 the residential program status elements were influenced by many change forces. These included the courts, advocacy groups, government agency actions and resource availability. Each of these were reviewed in detail.

This chapter traced the historical development of laws, population definitions and programs for the residential care of the retarded from 1960 to 1983. The change forces associated with shifts in each of the three categories were reviewed. The individual impact of each change force is difficult to assess but the cumulative influence on public policy in Michigan can be seen very clearly.

## CHAPTER V

### DISCUSSION

This dissertation traced the historical development of public policy associated with the residential care and treatment of mentally retarded people in the State of Michigan. It began with a review of the general development of services and programs within the United States and explored their historical basis. Using this national context, the evolution of Michigan programs was traced from Territorial times to the 1980s.

From 1895 until approximately 1960 residential services centered in the state's institutional system. A shift to community and home service began to occur in the 1960s. Those elements which influenced the change from institutional to community services were addressed in the last section of the thesis.

Chapter II reviewed the general history of residential care for the mentally retarded. It set the foundation and context for discussion of developments in Michigan. In the earliest times survival was society's central theme. Therefore, handicapped children often became victims of infanticide. As society developed, various views of what should be done with those who were

different than the mainstream also developed.

In the Middle Ages, care was provided locally by benevolence societies and religious groups. The mentally retarded often wandered about the countryside and were dubbed as town fools. Some of the court jesters of the 1500s and 1600s were more than likely people with mild mental retardation.

Asylums began to develop in eighteenth century Europe. The general category of insanity was applied to the mentally ill and mentally retarded alike, and all were often housed together in prison-like situations.

Care in the American colonies was a direct reflection of concepts developed in Europe. The mentally retarded were categorized as part of the pauper class and often cared for in alms houses. Relief systems were locally developed and usually based on English poor laws. In the early 1800s laws allowed for the retarded to be "cared for" in exchange for their labor on farms or in local industry.

By mid-century, experimental schools began to be developed for the mentally retarded. It was expected that that residents would be habilitated to a point where they could become functional members of society. During the last few decades of the century it was shown that such expectations seldom reached fruition, and a more paternalistic approach began to prevail. As American

society became more industrialized, the training schools evolved into places to protect the mentally retarded person.

By the turn of the century "scientific studies" were used as evidence that the mentally retarded were a threat to the fiber of the nation. Crime, pauperism, prostitution and illiteracy were linked to the mentally retarded. Large institutions became one mechanism to separate out this influence and stop the degradation of the nation. Public policy shifted from rehabilitation to segregation. Institutions continued to grow nationally in size and numbers until the mid-1960s.

Assisted by a national interest in human and civil rights, the 1960s were a time when care for the mentally retarded began to be centered in the community. Large isolated state hospitals were depopulated and state systems began to be decentralized.

Chapter III showed the historical parallels between national developments and those in Michigan prior to 1960. Initially Michigan lagged behind other states in providing care specifically for the mentally retarded. Until the very late 1800s many individuals were housed in county poor farms and state asylums for the insane. By the 1960s Michigan had become a national leader in care and treatment of the mentally retarded.

From its beginning Michigan public services provided



for citizens in need. Care was originally vested in county commissioners, as was the case in many states and territories. At about the same time statehood was granted, Michigan began to develop its policy of indoor relief. Care facilities for the poor were built on farms that were intended to be self-sufficient and provide work for residents. It was noted that these early investments of public funds in lands and buildings set precedents for future policy related to the care of the mentally retarded.

By the 1850s, Michigan had begun construction of asylums. The mentally retarded were often placed with the insane or were left in county alms houses, despite calls for special facilities designed specifically for them. Asylums were based on a strict hierarchical management system, with superintendents the final authority. This system influenced the development of services for decades.

During the last twenty years of the 1800s, the State of Michigan became firmly committed to the idea of providing for all of its unfortunate classes. A special facility for the feeble-minded was opened in 1895. Initially, supporters urged that this facility be a training school to assist in amelioration of mental retardation. But, by the time it opened, sentiment was changing toward the idea of segregation of defective

people. By the turn of the century Michigan had made a strong commitment to an institutional based care system.

Development of this total care system was furthered by the eugenics movement. Michigan was one of the first states to propose sterilization laws to stop the spread of mental retardation and associated vices. Institutions became the mechanism to carrying out these laws, while fulfilling the demands for segregation of the retarded. Institutions in Michigan became the means of implementing a public policy of protecting society from the retarded.

In the early twentieth century administrators became the chief proponents for developing larger institutions. They argued that institutions were providing a necessary service for the state. They were also considered the most efficient and economical method of care available. Centralized supervision, with power vested in medical superintendents, continued to be the form of administration utilized by the system through the 1950s.

By the 1950s, the necessity for specialized facilities for the mentally retarded was no longer debated. The system had become institutionalized as part of the state bureaucracy. At mid-century alternatives and additional services in local communities began to develop and the system began to depart from its isolated, independent form. Departmental and legislative scrutiny became more common and advocacy groups began to voice

problems they observed. By 1960 changes in care were beginning to take place.

Chapter IV reviewed the significant changes which occurred in Michigan's care system between 1960 and 1983. The central theme was identification of forces which influenced changes in the laws, population definitions and programs during the period. In the 1960s more people were residents in state institutions than at any time before; by 1983 populations had been reduced drastically. The large state hospital had been replaced by various types of small group homes located throughout the state. The concept of a single departmental system had been replaced by a decentralized community system.

The question addressed in this section of the thesis was, "What factors, over time, influenced public policy in the area of residential care and treatment for mentally retarded people?" In other words, what change forces impacted upon existing laws, population definitions and programs to allow for the diversification that occurred?

Using a modified version of a framework proposed by the Council of State Governments, five categories of change forces were reviewed. These were governmental initiatives, interest group actions, social consensus, resource availability and judicial opinion. It was shown that the laws of the period were influenced by parent

groups, governmental initiative and, to a limited degree, social consensus and judicial opinion. The public education and lobbying efforts of groups such as the Association for Retarded Citizens greatly influenced the establishment of community mental health legislation, mandatory special education laws and family support subsidies. Less formal coalitions of parents, with their children, influenced the legislative process with an intense, single issue focused campaign regarding institutional abuse and the need for community service. The Michigan Department of Mental Health influenced legislation establishing services in communities by arguing to maintain a degree of central control over county programs. The success of these arguments varied over the 23 year period discussed.

Social consensus and judicial opinion had more indirect impacts upon changes in the laws related to residential care in Michigan. The mood of the nation in the 1960s regarding human and civil rights certainly affected the people of Michigan. The adoption of the Handicapper's Civil Rights Act is an example of legislation that grew out of social consensus about rights and liberties in general.

The Michigan legislature was aware of judicial actions regarding the institution in Plymouth, Michigan, and other national cases. This awareness was peaked by

the fact that state officials were forced by a federal judge to appropriate funds to carry out a court decree. As a result, the legislature decided to encourage placement rather than be ordered by judicial action.

Michigan legislation between 1960 and 1983 focused on moving people into local communities. It culminated in 1983 with a law to encourage care within the family home. These changes were influenced by interest group actions and governmental initiatives, and to a lesser degree, judicial opinion and social consensus.

The second major element, the population, consisted initially of large numbers in state institutions and equally large waiting lists. As the period progressed, attention was given to those who were not residents of institutions. School system and advocacy group initiatives provided services to people within communities.

Although generally unnoticed by the majority of the population, social attitudes about the retarded began to slowly change. Resistance to establishment of group homes lessened and polls indicated the mentally retarded were no longer viewed as negatively as they had been in the past. Resistance still existed, but when compared to the views held in the 1920s, opposition to the retarded in the 1980s was minimal. Retardation was no longer linked to intemperance or criminal behavior as it had

been in earlier times. Although not always the will of the general public, changes in zoning laws, community education programs and court cases decided in favor of the retarded, all influenced public attitudes.

The third element analyzed in Chapter IV was program changes. It was shown that between 1960 and 1983 significant changes took place in residential programs. At the beginning of the period, state policy and resources were almost exclusively oriented toward state hospitals. These facilities and their programs had evolved over a seventy year period. By 1960 facilities had become very large and could no longer meet the demands and expectations for care and treatment placed upon them. By 1983, decisions had been made to close five facilities and cancel plans for construction of others. During this time the population in institutions decreased from over 12,000 people to approximately 2,000, with most being placed into small group community houses.

These changes, it was shown, were influenced by a combination of change forces. Judicial decisions ordered community placement of some institution residents and secured placements by enforcing zoning laws. Resource availability influenced legislative and executive decisions. As the cost of institution placements increased, the argument was that small group homes were cheaper, and family care even more economical.

Social consensus changed as more information was provided about the mentally retarded. People were sensitized by negative stories such as abuse in institutions and positive ones such as coverage of the Special Olympics. Voters suggested millage elections for special education. There was less resistance to community residences. While negative attitudes still existed in 1983, it was to a lesser degree than at the beginning of the period.

A number of governmental initiatives influenced programs. These ranged from inter-agency planning councils to the implementation of programs at a local level. Issues of administrative control and local flexibility were often debated. By 1983, residential care for the mentally retarded was no longer the sole domain of the Michigan Department of Mental Health, but was a shared responsibility with local community boards.

Interest groups, primarily families and associates of the mentally retarded advocating for improved living situations, exerted influence upon changing programs in many areas. In the 1960s such groups advocated for improvement of community services and resources. By 1983 many parents were involved in developing programs that would allow them to keep their children at home and provide care from within the family.

## Conclusions

In a general sense, public policy for the care and treatment of the mentally retarded in Michigan has come full circle. Responsibility for care began as a familial and local responsibility in Territorial times. It evolved into a centralized state controlled bureaucracy. It has now moved back to a local responsibility, followed by increased emphasis on family care.

Although laws, programs and population definitions have been modernized, it must be recognized that there remains much commonality with earlier times. Development of public policy is an iterative process, based on previous policy and on-going change factors.

This thesis has not attempted to weight the change factors influencing policy development in Michigan, it has simply attempted to identify them. Rarely does a single factor affect change alone. Rather, combinations of factors have an impact over time.

In Michigan before the 1950s there was little public policy related to the mentally retarded except provisions for institutional care. Policy that was developed was influenced by government officials more than anything else. Superintendents of the poor, the Board of Charities and Corrections and institution superintendents all greatly influenced care for the mentally retarded in



the late nineteenth and early twentieth centuries.

From the mid-1950s on, there were two factors that had great influence on the development of public policy. The first were governmental initiatives at both the state and federal levels. Within the state governmental system, influences came not only from those associated with institutions but from an expanded mental health bureaucracy and other state agencies.

The second major change force was interest group actions. Beginning in the 1950s parents of the mentally retarded organized into a potent lobbying force to impact upon policy development locally, state-wide and nationally. At times these interest groups were allied with government initiatives to formulate policy, while at other times policy was developed because of the opposition of these elements.

While other change forces influenced policy development, government initiative and interest group action appear to have been the most consistent elements of influence throughout this history. Both impacted greatly on the laws, population definitions and programs over time.

#### Limitations

The framework used in this thesis has several inherent limitations which must be recognized. The study

design limited analysis to identification of factors (change forces) which over time influenced public policy in the area of residential care and treatment of people who are mentally retarded in Michigan. It would have been virtually impossible to identify and associate each individual change force with establishment of specific policies. Likewise, no quantitative claims can be made about the relative weight of individual factors. The framework used to assist in organizing this study does not have the ability to provide these types of comparative analysis.

It is also noted that the Council of State Governments' framework was only applied to the period 1960 to 1983 (Chapter IV). The rationale for this is that until 1960 care and treatment was primarily based in the institutional system. Public policy, as demonstrated in Chapter III, was developed in relation to this system and very few factors influenced its limited focus. A broadened scope of public policies began to develop in the 1960s and continued into the 1980s. In addition to the limited scope of policy, the nature of the evidence available would have made identification of change factors very difficult prior to 1960, that is, the data base does not exist to support the use of the framework.

A second study limitation is the difficulty of identifying all of the status elements, change forces and

change settings that existed between 1960 and 1983. It was the intent of the research to identify major areas that have influenced public policy. For instance, identification of a single restrictive zoning covenant in a township in northern Michigan would have been insignificant to the analysis. However, discussion of state laws established to void restrictive zoning covenants was more germane to the scope of the study.

The central focus of this work was to develop a history of public policy related to the residential care and treatment of people with mental retardation. Future studies may provide opportunity to assess the relative weights of change forces and their quantitative impact upon policy development.

The very nature of historical research establishes limitations which must also be noted. Exploration had to be limited because of the massive amount of material about the mentally retarded. Developing a history necessitates selecting some pieces of information and deleting others. Another dilemma related to a history of public policy is that one often cannot determine motives and reasons behind the end policy product. It is necessary to be extremely careful in interpreting the thinking, motives and roles of policy makers, based on often limited information.

For these reasons this history attempted to identify

according to the research question, factors that influenced public policy in the area of residential care and treatment for the mentally retarded. To go beyond this point would be to go beyond the intent and capabilities of the study.

#### Subsidiary Questions

At the onset of the study several additional questions were raised. Information obtained provided varying degrees of response to these. Some offer a starting point for future research. The related questions were:

1. Have governmental or non-governmental organizations been the impetus behind policy changes for the retarded in Michigan? When one assesses the entire history of care for the retarded, beginning in the mid-nineteenth century it is apparent that formalized care has been a governmental function. The first urgings for development and educational institutions came from groups like the Conference of Corrections and Charities and organizations associated with County Superintendents of the Poor. These groups were the forerunners of the Corrections and Welfare Departments, but were not official governmental bodies. It must be remembered that Michigan state government was small and loosely organized at that time. It was not until the last few decades that

organized consumer groups have attempted to influence public policy. Over the long term governmental organizations seem to have influenced the care system for the retarded to a greater degree.

2. Have public policy changes come about due to legislative, administrative or judicial actions? This thesis did not provide enough information to distinguish between degrees of influence. Legislative actions certainly established the first institutions. The legislature continued to be involved over the years by funding and investigating facilities. These actions, however, often were the result of reports and requests from administrators. It was shown that institution administrators had a great deal of influence over the formation of public opinion about the retarded and, therefore, public policy. As community programs began to develop, issues of local versus state control were also raised by administrators. It is only recently that judicial actions have had an impact on policy. Information gathered in this study indicated that action by the courts expedited the process already underway.

3. What has been the impact of litigation on public policy for the retarded in Michigan? Litigation in Michigan has been primarily related to community placement and deinstitutionalization. Court decisions have made the process move faster than it might otherwise

have. Court orders were often time specific. It was also indicated that the legislature and the Department of Mental Health decided to take action to avoid further litigation.

4. Are there identifiable patterns within the development of Michigan's policy? From the establishment of county poor farms, the pattern for residential care was set for over 100 years. The first institutions for the poor were on large tracts of land which removed people from the center of society. The farms were generally self-sufficient and operated with resident labor. These patterns were repeated until the middle of the twentieth century.

Views of the client population and subsequent policy also appear to form a pattern. There were periods when emphasis was on providing for the individual person and other times when people were considered en masse. In retrospect, the periods of individualism seem to be more progressive, positive times; while the times of considering the group as a whole and congregating the mentally retarded appear to be stagnant, negative times.

Another pattern seems to be that policy has rarely been the result of planning. Rather, it seems to have developed as a result of crisis. From the decisions to fund the first facility in Lapeer to the closure of Plymouth Center, policy has been pushed by crisis. The

exception to this was the vast amount of planning in the 1960s. But, parts of these plans were often set aside because of various systems crises.

The arguments of economy and efficiency were continually presented to answer why some policies could be developed and implemented and others not. A State School in 1895 was an efficient way to train the feeble-minded. A subsidy to families in 1983 was more economical than placement. Economy and efficiency continue to be major themes in policy development.

5. How has state budgetary policy influenced residential care for the mentally retarded? Funding for construction and services has consistently been an issue in Michigan. The opening of the first institution was delayed because insufficient funds were appropriated to finish construction. Throughout the first half of the twentieth century plans for expansion and improvement of services were continually delayed by a lack of appropriations. The two extra legislative sessions in 1955 were called to address the problem of institutional waiting lists. As community mental health programs began, one delay was the local inability to meet the financial match necessary to receive state funds. Several administrators and legislators commented on how the budget crises of 1980 to 1982 forced community placement to occur much faster than the Department would

have preferred. Given this evidence, budgetary policy and fiscal conditions in the state have influenced residential care for the mentally retarded throughout the history reviewed by this dissertation.

6. Have changes in Michigan's public policy paralleled shifts in national public policy and periods of reform? In many instances policy development in Michigan has lagged behind other states, but once implemented, Michigan has become a leader. For example, construction of a separate institution for the mentally retarded was years behind other states; but once the system developed, facilities were some of the best (and certainly the largest) of the day. At the other end of the historical continuum, the study showed that Michigan was slow to develop a policy of deinstitutionalization; but once started the State became a national leader. The development of sterilization laws, colony programs, parole systems and community services all have followed national trends.

7. How have ideological concepts such as human rights and human potential influenced Michigan's policies? The study did not directly address these questions. Yet, as mentioned, policy in Michigan did follow national trends. For example, decisions in the Plymouth Center litigation were based on similar court cases which, in turn, used precedents set in civil rights



law. Similarly, the rights chapter written into the State Mental Health Code was greatly influenced by the national emphasis on human rights of the late 1960s.

#### Future Research

As is often the case with qualitative research, this study has served to generate additional questions for further research. Because of the global nature of the history specific areas could be explored in much greater detail. The role of individual administrators in policy development needs further examination. How did Charles Wagg, administrator for almost 30 years, influence mental health services in Michigan?

For more than 50 years the policy of sterilization of the mentally retarded was actively debated in Michigan. What elements influenced this debate? How did policy makers react to arguments for and against sterilization? What were the effects and results of Michigan's public policy in this area?

This study briefly discussed the policies of community placement and deinstitutionalization in Michigan. More in-depth study is needed to assess the merits, problems and long-term implications of these policies. A related issue is the administrative aspects of institution closure. How have administrators handled the closure process? What are the impacts of closure on

employee morale and service provision? Are there general policy statements that could improve the process?

Development of mental health law has been a long-term process in the state. This study discussed some of the processes. But, a detailed examination of the executive, legislative and administrative processes could be beneficial for future revisions and modifications of the system.

There are a large number of areas available for future policy research, including quantification of the concepts studied in this thesis. Mechanisms enabling an administrator to more precisely weigh the change factors that influence portions of policy could provide greater insight into the entire developmental process. Such methodology could be useful in modeling outcomes and projecting the impact of policy decisions.

#### Final Statement

Even the most elegant models and sophisticated projection techniques cannot totally replace qualitative, historic analysis. The purpose of this study has been to identify the factors that have influenced public policy related to mentally retarded people in the state of Michigan. No such history previously existed.

The significance of resource availability, judicial actions, social consensus, governmental initiatives and

interest group actions influencing laws, population definitions and programs does not lie simply in listing these factors. Rather, it is understanding and anticipating these change forces and how they influence public policy over time, that is significant.

In an attempt to be modern and progressive, public administrators tend to look at the present as the "best way," scorning the past. There often appears to be little understanding of how what has happened in the past influences present services, programs and planning.

The future of public policy for the mentally retarded in Michigan appears promising. While this thesis was not designed to be predictive, the history of care and treatment in Michigan indicates some major policy arenas which administrators must anticipate. First, inadequate research and erroneous interpretations of research can lead to public policy that does not benefit the retarded. At the beginning of this century eugenics research led to policies of isolation and segregation. In the 1980s preliminary family research has shaped the policy of keeping children at home with their biological families. Longitudinal studies are needed to determine the impact of such policy on other siblings, husband-wife relations and the over-all development of the mentally retarded child.

Second, standards must be established and maintained

for the type and quality of services to be provided. Institutions out grew the standards set for them and could not maintain a quality care level. Standards were eventually ordered by a federal court. As community systems grow larger, standards of care must be developed and keep pace with the demands of larger, more complex service systems. If these systems are not developed, community care programs face the possibility of repeating the failure of institutions to benefit mentally retarded citizens.

Coupled with the development of standards is the evaluation of community services to insure compliance. State facilities became self-contained units that monitored themselves for years. If community residences are not systematically evaluated, they too could become places that merely warehouse people instead of providing services of worth and merit.

Fourth, this history has shown that when long range planning is done, positive actions result. During the periods when no planning was done, treatment and care stagnated. Planning for the future must be an on-going process involving local and state agencies.

Fifth, planning must involve more than mental health agencies. Historically, service developments that included multiple agencies provided for a broader range of treatment options for the mentally retarded.

Cooperation in planning also lessens the competitive nature of the state and local budget process. Competition between agencies impedes the process of coordinated action. At a minimum, there must be administrative unity between and among service agencies.

Finally, the administrator must be aware of the issues related to funding from federal, state and local levels. This history has shown that as resource allocations shift, other service priorities and elements are influenced. Local funding provided local control of services, but there was a loss of uniform services. Federal funding has added funds to the state system, but also required changes in service standards. Changes in sources of program funding will continue to be an important element to monitor.

These are a few examples of the policy related areas that will confront administrators in the future, as they have in the past. How they are managed will determine the direction of care and treatment in Michigan. The framework used in this dissertation is one tool to account for the variables impacting upon systems and to assist in planning and evaluation of service systems. The state can continue its progress or it can return to problems faced in the institutions described in this dissertation. It will be the public administrators who play a key role in setting the directions of the future.

What must be remembered is that almshouses, asylums and state facilities were developed with good intentions. Future progress will not take place separate from the factors that have shaped Michigan's system to this point.

This study has shown that, generally, no one factor dictates change in public policy. Change is usually a combination of forces, occurring over time. The public administrator must learn to recognize and analyze change forces, and put them in proper perspective.

People who are mentally retarded have often been viewed in an ahistorical manner--emphasizing etiology, diagnosis, systems and bureaucracies. The social historical influence of mental retardation has often been forgotten. Administrators have been prone to see current public policy issues separate and apart from those of previous generations. This artificial separation of past and present should not be perpetuated.

History is linked to the future. By increasing knowledge about factors influencing the public policy of the past and seeing a continuum rather than isolated policy decisions, prospects for future policy development are enhanced. In the ideal, this view should guide the continuing development of public policy for people who are mentally retarded and living in Michigan. In the real sense, it will take change forces operating on existing status elements to affect necessary changes.

Appendix A  
Michigan Public Acts Affecting  
Mentally Retarded People

## Appendix A

Michigan Public Acts Affecting Mentally Retarded People

Act 209 of 1893	Michigan Home for Feeble-Minded and Epileptic later Lapeer State Home and Training School.
Act 173 of 1913	Established Michigan Farm Colony for Epileptics, later Caro State Hospital.
Act 163 of 1921	Jurisdiction of the State Home transferred to Institute Commission of State Welfare Department.
Act 151 of 1923	State Hospital Commission of Welfare Department established.
Act 324 of 1929	Hartman Act for Facility Construction.
Act 104 of 1937	State Hospital Commission made a separate governmental entity.
Act 214 of 1939	Director of Mental Hygiene established.
Act 271 of 1945	DMH replaces State Hospital Commission.
Act 148 of 1952	Statute language changed from feeble minded to mentally handicapped.
Act 4 of 1955 (1st Extra Session)	Allowed Special Education referendum in counties
Act 1 of 1955 (2nd Extra Session)	Emergency hospitalization of mentally deficient children.
Act 188 of 1956	\$50,00 to reimburse special education in local school districts; children under 16 eligible.



Act 148 of 1957	County day school programs for feeble-minded or epileptic children who cannot be educated in regular school.
Act 195 of 1958	Increased age to 21 for special education.
Act 182 of 1959	Licensure of houses caring for mentally ill, mentally handicapped and epileptic.
PA 111 of 1961	Howell State Hospital; formerly Howell Tuberculosis Sanatorium.
Act 21 of 1963	Gaylord State Home; formerly Northern Michigan Tuberculosis Sanatorium.
Act 54 of 1963	Community Mental Health programs created.
Act 236 of 1963	Reorganization of Department; abolition of Mental Health Commission.
Act 335 of 1965	Financial Liability of relatives limited.
Act 380 of 1965	Executive Organization Act; Department of Mental Health made principal of Executive Branch.
Act 198 of 1971	Mandatory Special Education.
Act 258 of 1974	Mental Health laws revised and codified.
Act 220 of 1976	Handicapper Civil Rights Act
Act 394-396 of 1976	Zoning acts to allow group homes of six or less.
Acts 397-398 of 1976	Foster care licensing acts.
Act 166 of 1978	Developmental Disability defined and rights further protected.
Act 249 of 1983	Family Support Subsidy Act.

**Appendix B**  
**Michigan Mental Retardation Chronology**

## Appendix B

## Michigan Mental Retardation Chronology

1805	Michigan Territorial Act for the Relief of the Poor passed.
1829	County poor houses authorized.
1859	Michigan Asylum for the Insane in Kalamazoo accepts its first patients.
1895	The first facility for "feeble-minded and epileptic" opens in Lapeer.
1906	Mechanical restraints are abolished in state facilities.
1914	Michigan Farm Colony for Epileptics is established in Wahjamega (Caro).
1920	County Departments of Social Welfare are developed.
1922	Wayne County Training School opened in Northville.
1923	The first State Hospital Commission, an advisory board, is authorized within the Welfare Department. Public Act 151 attempts to consolidate the mental health care system and laws organizing state hospitals.
1935	Michigan Children's Village for Defective Children is opened in Coldwater.
1937	Public Act 104 separates the State Hospital Commission from the State Welfare Department. A Central Office with authority for operating state hospitals is established.
1938	Federal Public Works Administration grants are made available for hospital construction.

- 1939            A change in statutes abolishes the position of Director of State Hospitals and creates that of Executive Secretary, to which Charles F. Wagg is appointed.
- A central department to direct the state mental health program is developed.
- 1945            Act 271 abolishes the State Hospital Commission and establishes a Department of Mental Health (DMH).
- 1946            Charles A. Zeller, M.D., becomes Mental Health Director.
- 1947            Charles F. Wagg is appointed Acting DMH Director.
- 1948            R. L. Dixon, M.D., Superintendent of the Caro State Hospital is appointed Acting DMH Director while continuing to serve as facility Administrator.
- 1949            Charles F. Wagg is again appointed DMH Director after the legislature changes statutes governing qualifications.
- 1955            Psychotropic drugs are introduced for the first time on a large scale basis.
- 1956            The legislature appropriates funds for the Plymouth State Home and Training School, Northville.
- Farmington Children's Hospital leased.
- Fort Custer leased from U.S. Army.
- 1960            Plymouth Center officially opens with 1,000 beds.
- The final report of the Citizen's Mental Health Inquiry Board is submitted, recommending centralization of DMH administration.
- 1961            Howell Sanatorium transferred to DMH and becomes Howell State Hospital.

- 1962 President John F. Kennedy calls for a more comprehensive, community-based approach to the care of the mentally disabled. The U.S. Congress passes the Mental Health Centers Construction Act (P.L. 88-164) which creates a funding mechanism for community mental health centers.
- 1963 The Michigan legislature passes the Community Mental Health Services Act (P.A. 54) which provides for development of community mental health boards as agencies of county government, responsible for developing local mental health services.
- Gaylord State Home opened.
- 1964 Robert A. Kimmich, M.D. is appointed DMH Director.
- \$1.5 million is appropriated to the five established community mental health boards.
- 1966 Vernon Stehman, M.D., is appointed Acting DMH Director.
- 1967 William Anderson, M.D., is appointed DMH Director.
- 1968 Michigan State Employee's Union holds a meeting in Pontiac where the decision is made to set the Department of Mental Health as a target for union organization.
- DMH Director, William Allen, M.D., submits to Governor William G. Milliken recommendations for a major legislative program that would rewrite Michigan's mental health laws.
- 1969 The Mental Health Program and State Review Commission is established by Executive Order.
- Muskegon Retardation Center opened.
- 1970 E. Gordon Yudashkin, M.D., is appointed DMH Director and establishes deinstitutionalization as a DMH program goal.

- 1971                      Public Act 198, Michigan's Mandatory Special Education Law is passed.
- Amendments to the Social Security Act establish provisions for Medicaid reimbursement to states for developmentally disabled patients residing in state institutions.
- 1972                      Fort Custer closed and residents moved to Plymouth and Northville centers.
- Mental Health Program and Statute Review Commission submits its report to the Governor, including recommendations for an integrated mental health code.
- 1973                      A Special Senate Committee to Study and Investigate the Programs and Policies of the Department of Mental Health is established.
- 1974                      Dr. E. Gordon Yudashkin resigns under fire and Donald C. Smith, M.D., is appointed Acting DMH Director.
- The State Legislature passes Act 258, "The Mental Health Code," which is signed into law by Governor William G. Milliken.
- 1976                      Regionalization of the mental health system occurs through the 1976 DMH reorganization plan.
- First year Medicaid payments for Michigan institutional services for the developmentally disabled reach \$80 million.
- Macomb-Oakland Regional Center is opened.
- 1977                      Final regulations for Medicaid Intermediate Care Facilities for the Mentally Retarded (ICF/MR) payments go into effect.
- Southgate Retardation Center is opened.

- 1978                    Allegations of abuse surface at Plymouth Center for Human Development. The Detroit Free Press begins a series of exposes on the Center. Dr. Donald Smith resigns. Suit filed in federal court.
- Vern Stehman, M.D., is appointed Acting DMH Director.
- Mental Health Code amended to include the term developmental disability instead of mental retardation.
- 1979                    Consent decree signed in Plymouth suit.
- In his State of the State message, Governor Milliken appoints a committee, chaired by Acting DMH Director Stehman, to study unification of the public mental health system stating, "The Michigan Mental Health code provides for the delivery of service through two separately administered systems at the state and county level, but requires that the Department of Mental Health coordinate and integrate these two systems."
- Frank Ochberg, M.D., is appointed DMH Director.
- Community homes in the Detroit area are a target of community resistance.
- St. Clair, Alger-Marquette, Washtenaw and Kent county community mental health boards are chosen to participate in a pilot study as "full management boards" responsible for caring for all county residents through a lump sum grant of annual operating funds.
- 1980                    Dr. Ochberg resigns as DMH Director.
- 1981                    C. Patrick Babcock is appointed DMH Director.

- 1981                   An Auditor General report of the Department of Mental Health finds evidence of mismanagement and possible fraud in the community placement program.
- Alpine Center (Gaylord) closed.
- 1982                   The Regional Director system is discontinued.
- Hillcrest Center (Howell) closed.
- 1983                   The Family Support Subsidy Act, an entitlement program for families of developmentally disabled children cared for at home, amends the Mental Health Code.
- Northville Retardation Center closed.
- 1984                   Plymouth Center closed.
- Within the state there are a total of 55 community mental health boards and eight centers for the developmentally disabled. Twenty-five of the CMH Boards have full management status.



## BIBLIOGRAPHY

- Abt, I. (1965). History of pediatrics. Philadelphia: W.B. Saunders.
- Abuse at Coldwater. (1958, April 17). The Detroit News, p.1.
- Acts of the Legislature of the State of Michigan (Vol. I). (1869). Lansing: W. S. George.
- Adams, J. (Ed.). (1976-1978). Dictionary of American history (Vols. 1-8). New York: Charles Scribner's Sons.
- Alexander, F., & Selesnick, S. (1966). The history of psychiatry. New York: Harper & Row.
- Allen, W. (Personal communication in an interview with R. L. Woell on February 21, 1985).
- Anderson, F. P. (1885). Imbeciles and idiots. Proceedings of the Conference of County Agents and Convention of the Board of Corrections and Charities (pp. 34-35). Lansing: Robert Smith.
- Anderson, W. H. (1969, May). A trilogy, Mental health in Michigan. Lansing: Michigan Department of Mental Health.
- Andrew, G. (1959, May 13). Memorandum to Dr. Stehman. (Department of Mental Health. Selected administrative correspondence. RG-71-73, box 25, folder 1). Lansing: Michigan State Archives, Department of State.
- Arben, P. Report to the commission, March 12, 1970. (Department of Mental Health. statute Revision Files. RG 79-61, box 1 folder 5). Lansing: Michigan State Archives, Department of State.
- Aristotle. (1943). Politics. (B. Jowett, Trans.). New York: Random House.
- Asexualization of criminals and degenerates. (1897). Michigan Law Journal, 6, 289-316.

- Ashbaugh, J. & Bradley, V. (1979, February). Linking deinstitutionalization of patients with hospital phase-down. Hospital and Community Psychiatry, 66-71.
- Association for Retarded Citizens/Michigan. (1984). The Plymouth case and decree. Lansing: Author.
- Association for Retarded Citizens/Oakland County. (1982). Resource guide on community placement for persons with mental retardation. Pontiac: Author.
- Babcock, C. P. (Personal communication in speech to the Community Mental Health Board on November 11, 1984. Lansing, MI).
- Babcock, P. C. (Personal communication in an interview with R. L. Woell on March 25, 1985).
- Bachrach, L. (1976). Deinstitutionalization: An analytical review and sociological perspective. National Institute of Mental Health (No. 76-351). Washington, DC: U.S. Government Printing Office.
- Bachrach, L. (1981). A conceptual approach to deinstitutionalization of the mentally retarded: A perspective from the experience of the mentally ill. In R. Bruininks, C. Meyers, B. Sigford & C. Lakin (Eds.), Deinstitutionalization and community adjustment of mentally retarded people (pp. 51-67). Washington, DC: American Association on Mental Deficiency.
- Balasalle, N. M. (1980). A history of public policy for the education of handicapped children in Massachusetts. Dissertation Abstracts International, 41, 3982-A. (University Microfilms No. 8100336).
- Barbour, L. (1893). Report on the national conference of charities and corrections. Proceedings of the Annual Conference of the Association of County Agents and Convention of the Board of Corrections and Charities (pp. 82-92). Lansing: Robert Smith.
- Barnett, L. R. (Personal communication to author, April 7, 1986).
- Barr, M. (1902). The imbecile and epileptic versus the tax-payer and the community. Proceedings of the National Conference of Charities & Corrections, 29, 161-165.

- Barr, M. (1904). Mental defectives: Their history, treatment and training. Philadelphia: P. Blakiston's Son.
- Barrett, J. E. (1938, January 28). Letter to John Anderson. (Department of Mental Health. Selected Executive Correspondence. RG-71-73, box 9, folder 2). Lansing: Michigan State Archives, Department of State.
- Bernstein, C. (1917). Self-sustaining feeble-minded. Journal of Psycho-Asthenics, 22, 150-161.
- Bernstein, N. R. (Ed.). (1970). Diminished people: Problems and care of the mentally retarded. Boston: Little, Brown.
- Berry, C. (1930). The aims and methods of education as applied to mental defectives. American Association for the Study of the Feeble-minded, Proceedings, 35, 68-72.
- Best, H. (1965). Public provision for the mentally retarded in the United States. Worcester, MA: Hefferman Press.
- Biklen, D. (Ed.). (1970). Human report. Observations in mental health--mental retardation facilities. Syracuse: Syracuse University, Division of Special Education.
- Board of Corrections and Charities. (1884). Report, 1883-84. Lansing: W. S. George.\*
- Board of Corrections and Charities. (1887). Report, 1885-86. Lansing: Thorp & Godfrey.
- Board of Corrections and Charities. (1888). Annual proceedings. Lansing: Thorp & Godfrey.
- Board of Corrections and Charities. (1901). Report. Lansing: Wynkoop, Hallenbeck, Crawford.
- Board of Corrections and Charities. (1904). Annual proceedings. Lansing: Robert Smith.

---

\*Due to the number of state documents, the Michigan element has been deleted from this bibliography. All state documents have been entered under the specific division of government.

- Board of State Commissioners for the General Supervision of Charitable, Penal, Pauper and Reformatory Institutions. (1875). Report. Lansing: W. S. George.
- Board of State Commissioners for the General Supervision of Charitable, Penal, Pauper and Reformatory Institutions. (1879). Report, 1877-78. Lansing: W. S. George.
- Blatt, B. (1970). Exodus from pandemonium: Human abuse and a reformation of public policy. Boston: Allyn and Bacon.
- Bogdan, R., & Taylor, S. (1976). The judged, not the judges: An insider's view of mental retardation. American Psychologist, 31, 47-52.
- Braddock, D. (1985a, April). From Roosevelt to Reagan: Federal spending for mental retardation and developmental disabilities. Unpublished manuscript, University of Illinois at Chicago, Institute for the Study of Developmental Disabilities, Chicago.
- Braddock, D. (1985b, July). Federal assistance for mental retardation and developmental disabilities II: The modern era 1962-'84. Unpublished manuscript, University of Illinois at Chicago, Institute for the Study of Developmental Disabilities, Chicago.
- Braddock, D., & Heller, T. (1984). The closure of MR institutions: Trends and implications (a working paper). Chicago: University of Illinois at Chicago, Institute for the Study of Developmental Disabilities.
- Braddock, D., Hemp, R., & Howes, R. (1984). Public expenditures for mental retardation and developmental disabilities in the U.S.: State profiles. Chicago: University of Illinois at Chicago, Institute for the Study of Developmental Disabilities.
- Braddock, D., Hemp, R., & Howes, R. (1985, March). Public expenditures for mental retardation and developmental disabilities in the United States: Analytical summary (Working Paper). Chicago: University of Illinois at Chicago, Institute for the Study of Developmental Disabilities.
- Bradley, V., & Agosta, J. (1985, November). Keeping your child at home, The case for family support. The Exceptional Parent, pp. 10-22.

- Braginsky, D., & Braginsky, B. (1971). Hansels and Gretels. New York: Holt, Rinehart & Winston.
- Breckinridge, S. (1938). Public welfare administration in the United States. Chicago: University of Chicago.
- Brown, C. (1955). Protest. Journal of the Senate, Second Extra Session (pp. 25-27). Lansing: Speaker-Hines & Thomas.
- Brown, S. (1931). Recommendations for Training the high grade mental defective in institutions for community life. Proceedings of the American Association for the Study of the Feebleminded, 36, 39-44.
- Browne, V. G., & Johnson, D. J. (1977). A guide to the state archives of Michigan: State records. Lansing: State Printing Office.
- Bruce, I., & Eickhoff, E. (1936). The Michigan poor law. Chicago: University of Chicago.
- Brucker, W. (1933). Message to the Fifty-seventh Michigan Legislature. Lansing: State of Michigan.
- Bruininks, R., Hauber, F., Hill, B., Lakin, C., McGuire, S., Rotegard, L., Scheerenberger, R., & White, C. (1983). 1982 national census of residential facilities: Summary report (Brief No. 21). Minneapolis: University of Minnesota, Center for Residential and Community Services.
- Bruininks, R. H., Meyers, C. E., Sigford, B. B., & Lakin, K. C. (Eds.). (1981). Deinstitutionalization and community adjustment of mentally retarded people. Washington, DC: American Association on Mental Deficiency.
- Buckmill, J. C., & Tuke, D. (1968). A manual of psychological medicine. New York: Hafner. (A facsimile of the 1858 edition.)
- Bullough, V., & Bullough, B. (1969). The emergence of modern nursing (2nd ed.). New York: Macmillan.
- Burdett, H. (1880). Pay hospitals and paying wards throughout the world. Philadelphia: Presley Blakiston.

- Burdett, H. (1891). Hospitals and asylums of the world. London: J. & A. Churchill.
- Butler, F. (1945). A quarter of a century's experience in sterilization of mental defectives in California. American Journal of Mental Deficiency, 49 (4), 508-513.
- Butler, F., & Gamble, C. (1947). Sterilization in a California school for the mentally deficient. American Journal of Mental Deficiency, 51 (4), 558-563.
- Byers, J. (1916). State plan for the care of the feeble-minded. Proceedings of the National Conference on Charities and Corrections, 43, 223-229.
- Byrne, J. C. (1869). Gheel, the city of the simple. London: Chapman and Hall.
- Campbell, F. (1986). [A history of Oakdale Center]. Unpublished research.
- Carlson, E., & Dain, N. (1960). The psychotherapy that was moral treatment. American Journal of Psychiatry, 117, 519-524.
- Carty, R. C., & Breault, G. C. (1967). Gheel: A comprehensive community mental health program. Perspectives in Psychiatric Care, 5 (6), 281-285.
- Cegelka, P. T. (Ed.). (1982). Mental retardation: From categories to people. Columbus: Merrill.
- Censoni, B. (Personal communication in an interview with R. L. Woell on March 4, 1985).
- Chamberlain, G. L. (1908). Feeble-minded and epileptic. Proceedings of the Annual Convention of the Michigan State Conference of Charities and Corrections (pp. 24-26). Lansing: Wynkoop, Hallenbeck, Crawford.
- Charron, R. (Personal communication in an interview on March 7, 1986).
- Chase, S. (Ed.). (1833). The statutes of Ohio and the Northwest Territory (Vol. I). Cincinnati: Corey & Fairbank.
- Coldwater Regional Center for Developmental Disabilities. (1981). Brochure. Coldwater, MI: Author.

- Commission to Investigate the Extent of Feeble-mindedness, Epilepsy and Insanity and Other Conditions of Mental Defectiveness in Michigan. (1915). Report. Lansing: Wynkoop, Hallenbeck, Crawford.
- Committee on Classification of Feeble-minded. (1910). Journal of Psycho-Asthenics, 15, 61-67.
- Cooley, T. (1885). Michigan: A history of governments. Boston: Houghton Mifflin.
- Cooper, J. C. (1984). Michigan handicappers' civil rights act. Michigan Bar Journal, 63, 826-830.
- Council of State Governments. (1978). The dynamics of public policy and the developmentally disabled. Lexington, KY: Author.
- Davidson, J. W., & Lytle, M. H. (1982). After the fact: The art of historical detection. New York: Knopf.
- Davies, S. P. (1959). The mentally retarded in society. New York: Columbia University.
- Deacon, K. (1952). An experiment in the cottage training of low-grade defectives. American Journal of Mental Deficiency, 47, 195-202.
- DeLeon, C. R. (Ed.). (1980). Michigan statutes annotated. Wilmette, IL: Callaghan.
- DeLoach, T. (Personal communication January 17, 1986).
- Demos, J. (1970). A little commonwealth: Family life in Plymouth Colony. New York: Oxford University Press.
- Department of Mental Health. Monthly population reports, 1922 to 1955. (Administrative files. RG62-41A, box 71, folder 2 and RG63-47A, box 3, folder 1). Lansing: Michigan State Archives, Department of State.
- Department of Mental Health. (1947). Monthly Bulletin, 2, 1-2.
- Department of Mental Health. (1950). A general plan for expanding Michigan's mental hospital facilities. Lansing: Author.

- Department of Mental Health. (1955a, September 22). Comparison of requests and legislative authorization of projects for mentally deficient between 1950 and 1955. (Administrative files. RG-71-73, box 24, folder 5). Lansing: Michigan State Archives, Department of State.
- Department of Mental Health. (1955b, October). A program for the emergency hospitalization of mentally retarded children. Lansing: Author.
- Department of Mental Health. (1955c). (Selected Executive Correspondence. RG-71-73, box 24, folder 2). Lansing: Michigan State Archives, Department of State.
- Department of Mental Health. (1960a). Program and activities report. Lansing: State of Michigan.
- Department of Mental Health. (1960b, September 28). Community mental health services in transition. Lansing: Author.
- Department of Mental Health. (1960c). (Citizen's Mental Health Inquiry Board file. RG 74-83, box 1, folder 1). Lansing: Michigan State Archives, Department of State.
- Department of Mental Health. (1961). (Community service legislation file. RG 74-84, box 1, folder 4). Lansing: Michigan State Archives, Department of State.
- Department of Mental Health. (1962a). The development and growth of Michigan's mental health program. Lansing: Author.
- Department of Mental Health. (1962b, January). Parents interest in institutionalization of patients waiting admission to state home and training schools. Lansing: Author.
- Department of Mental Health. (1962c, July 5). News release. (Administrative files. RG 74-67, box 1, folder 1). Lansing: Michigan State Archives, Department of State.
- Department of Mental Health. (1962d, December). An appraisal of Michigan's mental health program. Lansing: Author.



- Department of Mental Health. (1963a, February 26). Community programs organized. (News Release File. RG 74-67, box 1, folder 1). Lansing: Michigan State Archives, Department of State.
- Department of Mental Health. (1963b, April 24). Overcrowding continues for the retarded. (News Release File. RG 74-67, box 1, folder 1). Lansing: Michigan State Archives, Department of State.
- Department of Mental Health. (1966a). Michigan state plan for the construction of community facilities for the mentally retarded, 1965-66. Lansing: Author.
- Department of Mental Health. (1966b, July). A plan to combat mental retardation in Michigan. Lansing: Author.
- Department of Mental Health. (1967). A history of 130 years of transition and progress. Lansing: Author.
- Department of Mental Health. (1969a). Services for the mentally ill and mentally retarded in Michigan, Annual report 1968-1969. Lansing: Author.
- Department of Mental Health. (1969b, September 30). Bulletin. Members of mental health statute commission appointed. Lansing: Author.
- Department of Mental Health. (1970). Mental health program and statute review commission progress report. Statute Revision File. RG 79-61, box 1, folder 4. Michigan State Archives, Department of State.
- Department of Mental Health. (1978). Link. Michigan's mental health system. Lansing: Author.
- Department of Mental Health. (1984). Group homes: Alternatives to institutions. (A fact sheet published by the Office of Public Information, Lansing).
- Deutsch, A. (1946). The mentally ill in America. New York: Columbia University.
- Dexter, L. (1964). The tyranny of schooling. New York: Basic Books.
- Dix, P. (1843). Memorial to the legislature of Massachusetts. Old South Leaflets, 6 (148), 489-520.

- Dix, D. (1846). A review of the present condition of the state penitentiary of Kentucky. In D. Rothman (Ed.). On behalf of the insane poor (pp. 199-215). New York: Arno Press.
- Dix, D. (1847). Memorial soliciting enlarged and improved accommodations for the insane of the state of Tennessee. In D. Rothman (Ed.). On behalf of the insane poor (pp. 256-287). New York: Arno Press.
- Dix, D. (1848). Memorial of D. L. Dix praying a grant of land for the relief and support of the indigent curable and incurable insane in the United States. In D. Rothman (Ed.). On behalf of the insane poor (pp. 336-367). New York: Arno Press.
- Dix, D. (1852). Memorial of Miss D. L. Dix to the honorable the general assembly in behalf of the insane of Maryland. In D. Rothman (Ed.). On behalf of the insane poor (pp. 390-409). New York: Arno Press.
- Dixon, R. L. (1935, November, 21). Letter to F. Woodworth. (Department of Mental Health. Lapeer State Hospital. RG70-47, box 23, folder 1). Lansing: Michigan State Archives, Department of State.
- Doll, E. (1929). Community control of the feeble-minded. Proceedings of the American Association for the Study of the Feeble-minded, 34, 161-174.
- Down, J. (1887). Mental affections of children and youth. London: J. & A. Churchill.
- Dror, Y. (1986). Policymaking under adversity. New Brunswick, NJ: Transaction Books.
- Dugdale, R. (1910). The Jukes: A study in crime, pauperism, disease, and heredity (3rd ed.). New York: G. P. Putnam's Sons.
- Dumont, M., & Aldrich, C. K. (1962). Family care after a thousand years -- A crisis in the tradition of St. Dymphna. American Journal of Psychiatry, 119, 117-121.
- Duncan, P., & Millard, W. (1866). A manual for the classification, training, and education of the feeble-minded, imbecile and idiotic. London: Longmans, Green.

- Durant, W. (1935). Our oriental heritage. New York: Simon and Schuster.
- Durant, W. (1939). The life of Greece. New York: Simon and Schuster.
- Durant, W. (1944). Caesar and Christ. New York: Simon and Schuster.
- Durant, W. (1950). The age of faith. New York: Simon and Schuster.
- Eastern Michigan Asylum at Pontiac. (1880). Report of the Board of Trustees. Lansing: W. S. George.
- Eliot, C. (Ed.). (1910). The Harvard classics: American historical documents (Vol. 43). New York: Collier.
- Erickson, K. (1966). Wayward Puritans: A study of the sociology of deviance. New York: John Wiley & Sons.
- Esquirol, J. (1965). Mental maladies: A treatise on insanity. London: Hafner. (A facsimile of the 1845 edition.)
- Ettinger, C. M. (1984). Accommodating the handicapped employee: When is the burden undue? Michigan Bar Journal, 63, 831-834.
- Farber, B. (1968). Mental retardation: It's social context and social consequences. Boston: Houghton Mifflin.
- Fernald, W. (1893). The history of the treatment of the feeble-minded. Proceedings of the National Conference of Charities & Correction, 20, 203-221.
- Fernald, W. (1912). The burden of feeble-mindedness. Journal of Psycho-Asthenics, 17, 85-111.
- Fernald, W. (1915). What is practical in the way of prevention of mental defect? Proceedings of the National Conference of Charities & Correction, 42, 289-297.
- Fernald, W. (1924). Thirty years progress in the care of the feeble-minded. American Association for the Study of the feeble minded, Proceedings, 29, 206-219.

- Ferris, W. (1913). Governor's address. Journal of Psycho-Asthenics, 18, 67-72.
- Fish, C., & Foster, C. (1956). Admission procedures and policies in state institutions for the mentally retarded. American Journal of Mental Deficiency, 61, 317-327.
- Fitzgerald, F. (1935). Message of the Governor to the fifty-eighth Michigan legislature. Lansing: State of Michigan.
- Foley, R. (1929). A study of the patients discharged from Rome State School for the twenty year period ending December 31, 1924. American Association for the Study of the Feeble-minded, Proceedings, 34, 180-204.
- Forrest, H. (1890). Legislation of 1889 in penal and pauper matters. Proceedings of the Conference of County Agents and Confention of the Board of Corrections and Charities (pp. 41-48). Lansing: Robert Smith.
- Freeman, D., Ott, W., & Dunsmore, M. (1956). School program for mentally retarded adults. American Journal of Mental Deficiency, 61, 94-104.
- Friedlander, L. (1928). Roman life and manners under the early empire (Vols. 1-4). (J. H. Freese and L. Magnus, Trans.). New York: E. P. Dutton. (Original published in 1919.)
- Friedman, L. (1974). A history of American law. New York: Simon and Schuster.
- Fuller, G. (Ed.). (1926). Messages of the governors of Michigan (Vol. II). Lansing: Michigan Historical Commission.
- Fuller, G. (Ed.). (1927a). Messages of the governors of Michigan (Vol. III). Lansing: Michigan Historical Commission.
- Fuller, G. (Ed.). (1927b). Messages of the governors of Michigan (Vol. IV). Lansing: Michigan Historical Commission.
- Fuller, G. (Ed.). (1939). Michigan, A centennial history of the state and its people (Vol. II). Chicago: Lewis.

- Gail, M. (1968). Life in the Renaissance. New York: Random House.
- Gallichan, W. (1929). The sterilization of the unfit. London: T. Werner Laurie.
- Gamble, C. (1949). Trends in state programs for the sterilization of the mentally deficient. American Journal of Mental Deficiency, 53 (4), 538-541.
- Gillespie, G. (1887). Does Michigan need an institution for the feeble-minded and idiotic? Proceedings of the Conference of County Agents and Convention of the Board of Corrections and Charities (pp. 89-94). Lansing: Robert Smith.
- Glaser, B. G., & Strauss, A. L. (1967). The discovery of grounded theory: Strategies for qualitative research. New York: Aldine.
- Glass, H. (1955, October 25). Memorandum to Charles Wagg regarding hospital waiting lists. (Department of Mental Health. Selected Administrative Correspondence. RG 63-47-A, box 3, folder 8). Lansing: Michigan State Archives, Department of State.
- Goffman, I. (1963). Stigma. Englewood Cliffs, NJ: Prentice-Hall.
- Goldstein, H. (1959). Population trends in U.S. public institutions for the mentally deficient. American Journal of Mental Deficiency, 63, 599-604.
- Governor's Statute Commission. (various dates). Minutes. (Department of Mental Health. Statute Revision Files. RG 79-61, box 1, folder 5). Lansing: Michigan State Archives, Department of State.
- Graney, B. (1979). Hervey Backus Wilbur and the evolution of policies and practices toward mentally retarded people. Dissertation Abstracts International, 40, 6229-A. (University Microfilms No. 8013376).
- Haller, M. (1963). Eugenics; Hereditarian attitudes in American thought. New Brunswick, NJ: Rutgers University.
- Halpern, J., Sackett, K., Binner, P., & Mohr, C. (1980). The myths of deinstitutionalization: Policies for the mentally disabled. Boulder: Westview.

- Harms, E. (1976). The historic aspect of child psychiatry. In R. Jenkins & E. Harms (Eds.), Understanding disturbed children (pp. 10-24). Seattle: Special Child Publications.
- Harris, G. A. (1963). Programs for the mentally handicapped for the 1962-63 school year. (Department of Mental Health. Mentally Retarded Training File. RG 74-84, box 1, folder 14). Lansing: Michigan State Archives, Department of State.
- Hegge, T. (1952). Children with mental and emotional disabilities. A symposium held in celebration of the 25th anniversary of the Wayne County Training School in Northville, Michigan. American Journal of Mental Deficiency, 56, 665-700.
- Henry, G. W. (1941). Mental hospitals. In G. Zilboorg. A history of medical psychology (pp. 558-589). New York: W. W. Norton.
- Herman, S. (1986, February). Family support subsidy program evaluation report: FY 84-85. Lansing: Michigan Department of Mental Health.
- Hill, B. K., & Lakin, K. C. (1984). Trends in residential services for mentally retarded people: 1977-1982 (Brief No. 23). Minneapolis: University of Minnesota, Center for Residential and Community Services.
- Hilliard, L., & Kirman, B. (1965). Mental deficiency. London: J. & A. Churchill.
- Hillway, T. (1964). Introduction to research. Boston: Houghton Mifflin.
- Hoffman, P. B., & Dunn, R. (1975). Beyond Rouse and Wyatt: An administrative law model for expanding and implementing the mental patients right to treatment. Virginia Law Review, 51 (2), 297-339.
- House Legislative Analysis Section. (1976, December 15). Analysis of House Bill 4893, Second. Lansing: Author.
- House Legislative Analysis Section. (1983, December 21). Analysis of House Bill 4448, Third. Lansing: Author.

- House Mental Health Committee. (1974, February 7). Minutes. (Legislative files. RG 79-98, box 5, folder 2). Lansing: Michigan State Archives, Department of State.
- Hughes, J. E. (1940). Eugenical sterilization in the United States. U.S. Public Health Reports, Supp. No. 162. Washington, DC: U.S. Government Printing Office.
- Hunt, J. K. (1983). The closing of NRTC: A humanitarian legacy. Unpublished manuscript.
- Hurley, R. (1969). Poverty and mental retardation. New York: Vintage Books.
- Ireland, W. (1887). On idiocy and imbecility. London: J. & A. Churchill.
- Itard, J. (1962). The wild boy of Aveyron. (G. Humphrey & M. Humphrey, Trans.). New York: Meredith. (Original work published in 1907.)
- Johnson, A. (1897). Minutes of the association, twenty-first session. Journal of Psycho-Asthenics, 2, 31-47.
- Johnson, A. (1899). Concerning a form of degeneracy. The American Journal of Sociology, 4 (4), 463-473.
- Johnstone, E. (1916). Stimulating public interest in the feeble-minded. Proceedings of the National Conference on Charities and Corrections, 43, 205-215.
- Johnstone, E. R. (1931). Report of the Committee on Mental Deficiency of the White House conference. Journal of Psycho-Asthenics, 36, 339-350.
- Joint documents of the Michigan Legislature (Vol. I). (1841). Detroit: George Dawson.
- Joint documents of the Legislature of the State of Michigan. (1850). Lansing: R. W. Ingals.
- Joint documents of the Legislature of the State of Michigan. (1851). Lansing: R. W. Ingals.
- Joint Legislative Committee on Reorganization of State Government. (1951). General management of Michigan state government. (Report No. 30). Lansing: State of Michigan.

- Joint Mental Health Oversight Committee. (1980).  
Community placement of mentally disabled persons in Michigan. Lansing: State of Michigan.
- Journal of the House of Representatives. (1877).  
 Lansing: W. S. George.
- Journal of the House of Representatives. (1955a).  
 Lansing: State of Michigan.
- Journal of the House of Representatives. (1955b).  
 Lansing: State of Michigan.
- Journal of the house of represenatives. (1961).  
 Lansing: State of Michigan.
- Journal of the House of Representatives. (1962).  
 Lansing: State of Michigan.
- Journal of the House of Representatives. (1963).  
 Lansing: State of Michigan.
- Journal of the House of Representatives. (1964).  
 Lansing: State of Michigan.
- Journal of the House of Representatives. (1969).  
 Lansing: State of Michigan.
- Kanner, L. (1964). A history of the care and study of the mentally retarded. Springfield, IL.: Charles C. Thomas.
- Kebler, G. (1963). Funding aid for the records of the Department of Mental Health, 1922-1961. The Archives Index (Vol. 40). Lansing: Michigan Historical Commission.
- Kelly, H. (1943). Message of the Governor to the sixty-second Michigan Legislature. Lansing: State of Michigan.
- Kelly, H. (1945). Message to the sixty-third Michigan Legislature. Lansing: State of Michigan.
- Kelly, H. (1945). Progress report. Lansing: State of Michigan.
- Kelly, H. (1946). A report to the Michigan Legislature, 1943-1946. Lansing: State of Michigan.



- Kerlin, I. (1884). Provision for idiotic and feeble-minded children. Proceedings of the National Conference of Charities & Correction, 11, 246-263.
- Kerlin, I. (1888). Status of the work. Proceedings of the Association of Medical Officers of American Institutions for Idiotic and Feeble-minded Persons, 12, 79-82.
- Kerlin, I. N. (1889). Moral imbecility. A paper presented at the association of medical officers of American institutions for idiotic and feeble-minded persons. In M. Rosen, G. Clark & M. Kivitz (Ed.), The history of mental retardation (pp. 303-310). Baltimore: University Park Press.
- Knight, G. (1888). President's address. Proceedings of the Association of Medical Officers of American Institutions for Idiotic and Feeble-minded Persons, 12, 51-53.
- Knight, G. (1891). Discussion of custodial care of adult idiots. Proceedings of the Association of Medical Officers of American Institutions for Idiotic and Feeble-minded Persons, 15, 211-218.
- Kock, R. (1969). Annual presidential message to the AAMD membership. American Journal of Mental Deficiency, 74, 2-4.
- Kowalski, J. (1961, July 25). Legislative newsletter. (Department of Mental Health. Administrative files. RG 77-67, box 2, folder 6). Lansing: Michigan State Archives, Department of State.
- Kraft, I. (1961). Edouard Seguin and 19th century moral treatment of idiots. Bulletin of the History of Medicine, 35, 393-418.
- Kretchmer, N. (1964). Whither birth defects. Perspectives in Biology and Medicine, 8 (1), 15-29.
- Krishef, C. H. (1983). An introduction to mental retardation. Springfield, IL: Charles C. Thomas.
- Kuhlman, F. (1940). One hundred years of special care and training. American Journal of Mental Deficiency, 45, 8-24.

- Lakin, K. C. (1979). Demographic studies of residential facilities for the mentally retarded: A historical review of methodologies & findings. Minneapolis: University of Minnesota, Department of Pshych-educational Studies.
- Laughlin, H. (1922). Eugenical sterilization in the United States. Chicago: Psychopathic Laboratory of the Municipal Court.
- Laws of the Territory of Michigan (Vol. I). (1871). Lansing: W. S. George.
- Laws of the Territory of Michigan (Vol. II). (1874). Lansing: W. S. George.
- Little, A., & Johnson, B. (1932). A study of the social and economic adjustments of 113 discharged parolees from Laconia State School. Proceeding of the American Association for the Study of the Feeble-minded, 37, 233-48.
- Magnuson, P., & Watson, S. (1978, February 19). Children tortured; State center covers up. The Detroit Free Press, pp. 1-A, 10-A.
- Malson, L. (1972). Wolf children and the wild boy of Aveyron. (E. Fawcett, P. Ayrton & J. White, Trans.). London: National Language Board. (Original work published in 1964.)
- Manceron, C. (1977). Twilight of the old order--1774-1778. (P. Wolf, Trans.). New York: Alfred A. Knopf. (Original work published in 1972.)
- McCulloch, O. (1888). The tribe of Ishmael: A study in social degradation. Proceedings of the National Conference of Charities & Correction, 15, 154-159.
- McEwan, O. (Mrs.). (1937, December 2). Letter to J. Milliken. (Department of Mental Health. Selected executive correspondence. RG-71-73, box 9, folder 2). Lansing: Michigan State Archives, Department of State.
- McKercher, H. J. (1951, October 30). Letter to Governor G. Mennen Williams. (Department of Mental Health. Selected correspondence. RG 66-69-A, box 5, folder 1). Lansing: Michigan State Archives, Department of State.

- Mental Health Commission. Minutes. (1959, April 17).  
(Department of Mental Health. Selected administrative documents. RG 71-73, box 25, folder 2). Lansing: Michigan State Archives, Department of State.
- Mercer, J. (1976). Labelling the mentally retarded. Berkely: University of California Press.
- Meyers, C. E. (Ed.). (1978). Quality of life in severely and profoundly mentally retarded people: Research foundations for improvement. Washington, DC: American Association on Mental Deficiency.
- Michigan. (1886). Census of the State of Michigan--1884. Lansing: Thorp & Godfrey.
- Michigan. (1891). Statistical information relative to the insane, deaf and dumb, and blind in the State of Michigan--1890. Lansing: Robert Smith.
- Michigan Association for Retarded Citizens v. Smith, 475 F. Supp. 990 (ED Mich. 1979).
- Michigan Asylum for the Insane. (1859). Report of the Board of Trustees. Lansing: Hosmer & Kerr.
- Michigan Asylum for the Insane. (1861). Biennial report. Lansing: Hosmer & Kerr.
- Michigan Asylum for the Insane. (1868). Report of the Board of Trustees. Lansing: John A. Kerr.
- Michigan Asylum for the Insane. (1877). Report of the Board of Trustees. Lansing: W. S. George.
- Michigan Asylum for the Insane. (1879). Report of the Board of Trustees. Lansing: W. S. George.
- Michigan Asylum for the Insane. (1880). Report of the Board of Trustees. Lansing: W. S. George.
- Michigan compiled laws annotated (Vol. 16-A). (1980). St. Paul: West Publishing.
- Michigan compiled laws annotated (Vol. 17-A). (1985). St. Paul: West Publishing.
- Michigan Home for the Feeble-minded and Epileptic. (1896). Report of the Board of Control. Lansing: Robert Smith.

- Michigan Home for the Feeble-minded and Epileptic.  
(1898). Report of the Board of Control. Lansing:  
Robert Smith.
- Michigan Home for the Feeble-minded and Epileptic.  
(1900). Report of the Board of Control. Lansing:  
Wynkoop, Hallenbeck & Crawford.
- Michigan Home for the Feeble-minded and Epileptic.  
(1903). Report of the Board of Control. Lansing:  
Robert Smith.
- Michigan Home for the Feeble-minded and Epileptic.  
(1904). Report of the Board of Control. Lansing:  
Wynkoop, Hallenbeck, & Crawford.
- Michigan Home for the Feeble-minded and Epileptic.  
(1906). Report of the Board of Control. Lansing:  
Wynkoop, Hallenbeck, & Crawford.
- Michigan Home for the Feeble-minded and Epileptic.  
(1913). Report of the Board of Control. Lansing:  
Wynkoop, Hallenbeck, & Crawford.
- Michigan Home and Training School. (1914). Report of  
the Board of Control. Lansing: Wynkoop, Hallenbeck,  
& Crawford.
- Michigan Home and Training School. Annual reports:  
1945-1949. (Michigan Department of Mental Health.  
Subject Files. RG63-47-A, box 4, folder 1). Lansing:  
Michigan State Archives, Department of State.
- Michigan Manual. (1857). Lansing: Hosmer & Fitch.
- Michigan Manual. (1960). Lansing: State of Michigan.
- Michigan Public Act 187 of 1848.
- Michigan Public Act 194 of 1877.
- Michigan Public Act 225 of 1881.
- Michigan Public Act 209 of 1893.
- Michigan Public Act 235 of 1895.
- Michigan Public Act 136 of 1905.
- Michigan Public Act 150 of 1913.

- Michigan Public Act 163 of 1921.
- Michigan Public Act 151 of 1923.
- Michigan Public Act 281 of 1929.
- Michigan Public Act 324 of 1929.
- Michigan Public Act 104 of 1937.
- Michigan Public Act 214 of 1939.
- Michigan Public Act 271 of 1945.
- Michigan Public Act 111 of 1961.
- Michigan Public Act 380 of 1965.
- Michigan Public Act 249 of 1983.
- Michigan State Asylums. (1857). Biennial report.  
Lansing: Hosmer & Fitch.
- Millard, M. (1886). Letter from M. Millard.  
Proceedings of the Association of Medical Officers of  
American Institutions for Idiotic and Feeble-minded  
Persons (pp. 392-394). Philadelphia: J.B. Lippincott.
- Miller, S. (Personal communication in an interview with  
R. L. Woell on March 19, 1985).
- Milliken, W. G. (1975, January). State of the State  
address. Lansing: State of Michigan.
- Moore, A. E. (1955, March 24). Letter to Governor  
Williams. (Department of Mental Health. RG71-73, box  
24, folder 2). Lansing: Michigan State Archives,  
Department of State.
- Murdock, J. (1913). State care for the feeble-minded.  
Journal of Psycho-Asthenics, 18, 34-45.
- Murphy, F. (1937). Message to the Fifty-ninth Michigan  
Legislature. Lansing: State of Michigan.
- Osborne, A. (1891). The founding of a great institution  
and some of its problems. Proceedings of the  
Association of Medical Offices of American  
Institutions for Idiotic and Feeble-minded Persons, 15,  
173-185.

- Otness, H. (1950). A population inventory. American Journal of Mental Deficiency, 55, 20-22.
- Payne, G. H. (1916). The child in human progress. New York: J. H. Sears.
- Pinel, P. (1962). A treatise on insanity. (D.D. Davis, Trans.). New York: Hafner. (Original work published in 1806.)
- Pinkelman, F. C. (1984). Treatment outcome review, Department of Mental Health: January 1, 1978 through September 30, 1983. Lansing: Office of the Auditor General.
- Plachetka, T. (Personal communication in an interview on March 19, 1985).
- Plato. (1928). The Republic. (B. Jowett, Trans.). New York: Carlton.
- Polglase, W. (1897). The feeble minded. Proceedings of the Annual Conference of the Association of County Agents and the Convention of the Board of Corrections and Charities (pp. 91-98). Lansing: Robert Smith.
- Polglase, W. (1899). The epileptic a ward of the state. Proceedings of the Annual Conference of the County Agents and the Confention of the Board of Corrections and Charities (pp. 86-88). Lansing: Robert Smith.
- Polglase, W. (1900). Discussion. Proceedings of the National Conference of Charities and Corrections, 27, 425-426.
- Polloway, E. A., & Payne, J. S. (1975). Comparison of the AAMD Heber and Grossman manuals on terminology and classification in mental retardation. Mental Retardation, 13 (3), 12-14.
- President's Committee on Mental Retardation. (1977). Mental Retardation: Past and Present (Stock No. 040-000-00385-1). Washington, DC: U.S. Government Printing Office.
- President's Committee on Mental Retardation. (1980). Gallup poll shows attitudes on MR improving. Washington, DC: U.S. Department of Health, Education and Welfare.

- President's Panel on Mental Retardation. (1962). A proposal program for national action to combat mental retardation. Washington, DC: U.S. Government Printing Office.
- Quade, E. S. (1975). Analysis for public decisions. New York: Elsevier.
- Raymond, C. (1948). The development of the program for the mentally defective in Massachusetts for the past one hundred years (1848-1948). American Journal of Mental Deficiency, 53, 80-91.
- Reports of institutions for idiots. (1852). American Journal of Insanity, 9, 20-36.
- Revised Statutes of the State of Michigan. (1838). Detroit: John S. Bagg.
- Revised Statues of the State of Michigan. (1846). Detroit: State of Michigan.
- Richards, L. (1909). Letters and journals of Samuel Gridley Howe, the servant of humanity. Boston: Dana Estes.
- Risley, S. (1905). Is asexualization ever justified in the case of imbecile children. Journal of Psycho-Asthenics, 9, 92-98.
- Rivera, G. (1970). Willowbrook: A report on how it is and why it doesn't have to be that way. New York: Vintage.
- Rogers, A. (1898). Does the education of the feeble-minded pay? Journal of Psycho-Asthenics, 2, 152-154.
- Rosen, M., Clark, G. R., & Kivitz, M. S. (Eds.). (1976). The history of mental retardation (Vols. 1 & 2). Baltimore: University Park Press.
- Rozelle, E. (1954). Some principles and philosophy in the planning and development of institutional plants. American Journal of Mental Deficiency, 58, 595-624.
- Ruhrah, J. (1925). Pediatrics of the past. New York: Paul B. Holber.

- Salisbury, A. (1891). The education of the feeble-minded. Proceedings of the Association of Medical Officers of American Institutions for Idiotic and Feeble-minded Persons, 15, 219-233.
- Sanborn, F. B. (1891). Dr. S. G. Howe, the philanthropist. New York: Funk & Wagnalls.
- Sanderson, J. (1909). Our county poorhouses. Proceedings of the Annual Convention of the Michigan State Conference of Charities and Corrections (pp. 56-66). Lansing: Wynkoop, Hallenbeck, Crawford.
- Sandoz Corporation letter. (1960, December 12). (Department of Mental Health. Selected administrative correspondence. RG-77-89, box 1, folder 7). Lansing: Michigan State Archives, Department of State.
- Sarason, S. B., & Doris, J. (1979). Educational handicap, public policy, and social history. New York: The Free Press.
- Scheerenberger, R. (1976). Deinstitutionalization and institutional reform. Springfield, IL: Charles C. Thomas.
- Scheerenberger, R. (1980a). The impact of court actions on recent trends in service delivery. In P. Roos, B. McCann, & M. Addison (Eds.), Shaping the Future: Community-Based Residential Services and Facilities for Mentally Retarded People (pp. 83-93). Baltimore: University Park Press.
- Scheerenberger, R. (1980b). Public residential services for the mentally retarded, 1979. Madison, WI: National Association of Superintendents of Public Residential Facilities for the Mentally Retarded.
- Scheerenberger, R. C. (1983). A history of mental retardation. Baltimore: Brookes.
- Schwartz, H. (1956). Samuel Gridley Howe, social reformer. Cambridge: Harvard University.
- Schwindler, W. (1974). Court and constitution in the 20th century. Indianapolis: Bobbs-Merrill.
- Seguin, E. (1866). Idiocy and its treatment by the physiological method. New York: William Wood.



- Sellin, D. F. (1979). Mental retardation: Nature, needs, and advocacy. Boston: Allyn and Bacon.
- Sellin, D., Cross, M., Deiter, J., Harris, G., Harrison, D., Peterson, A., Smith, R., & Zimmerman, H. (1974). Opinions regarding interagency programming for the mentally retarded. Mental Retardation, 12 (4), 24-28.
- Selznick, P. (1957). Leadership in administration: A sociological interpretation. New York: Harper & Row.
- Senate journal. (1955a). Lansing: State of Michigan.
- Senate journal. (1955b). Lansing: State of Michigan.
- Senate journal. (1961). Lansing: State of Michigan.
- Senate journal. (1962). Lansing: State of Michigan.
- Senate journal. (1963). Lansing: State of Michigan.
- Senate journal. (1964). Lansing: State of Michigan.
- Shartel, B. (1925). Sterilization of mental defectives. Michigan Law Review, 24, 1-21.
- Sherman, L. (1894). What we propose to do in and what we expect from our home for the feeble-minded and epileptic. Proceedings of the Annual Conference of the Association of County Agents and Convention of the Board of Corrections and Charities (pp. 80-83). Lansing: Robert Smith.
- Shuttleworth, G. (1877). Notes of a Visit to American Institutions for Idiots and Imbeciles. Lancaster, England: Putman.
- Sloane, W. (1963). Four score and seven. American Journal of Mental Deficiency, 68, 6-14.
- Smith, J. D. (1985). Minds made feeble. Rockville, MD: Aspen Systems.
- Smith, J. S. (1914). Marriage, sterilization and commitment laws aimed at decreasing mental deficiency. Journal of the American Institute of Criminal Law and Criminology, 5 (3), 364-370.

Smith, W. (1965). Letters to Department of Mental Health Administrators. (Department of Mental Health. RG 75-106, box 6, folder 7). Lansing: Michigan State Archives, Department of State.

Solecki, R. (1971). Shanidar. New York: Alfred A. Knopf.

Special Commissioners to Examine the Penal, Reformatory and Charitable Institutions of the State of Michigan. (1871). Report. Lansing: W. S. George.

Stabenow, D. (Personal communication in an interview with R. L. Woell on February 20, 1985).

Stabenow, D. (Personal communication in an interview conducted on February 20, 1986).

State Hospital Commission. (December 12, 1924). Minutes. (Department of Mental Health. Subject Files. RG75-21, box 1, folder 2). Lansing: Michigan State Archives, Department of State.

State Hospital Commission. (1939). Statistical Report: 1935-1938. Lansing: Author.

State Interagency Cadre on Mental Retardation. (1967). Report. (Department of Mental Health. Subject Files. RG75-17, box 2, folder 6). Lansing: Michigan State Archives, Department of State.

Stehman, V. A. (1959, February 27). Letter to F. M. Landers, State Budget Director. (Department of Mental Health. Selected administrative correspondence. RG-71-73, box 25, folder 1). Lansing: Michigan State Archives, Department of State.

Stehman, V. A. (Personal communication in an interview with R. L. Woell on February 27, 1985).

Sterilization law praised. (1936, October 25). The Detroit News, p. 1.

Stewart, J. (1882). Status of the work. Proceedings of the Association of Medical Officers of American Institutions for Idiotic and Feeble-minded Persons, 5, 269-271.

- Stillman, R. J. (1982). The changing patterns of public administration theory in America. In J. A. Uveges (Ed.). Public Administration, History and Theory in Contemporary Perspective (pp. 5-38). New York: Merce! Dekker.
- Storrs, H. (1950). Place of the institution in state programs for the care and supervision of the mentally deficient. American Journal of Mental Deficiency, 54, 178-181.
- Storrs, L. C. (1896). Legislation of 1895. Proceedings of the Annual Conference of the Association of County Agents and Convention of the Board of Corrections and Charities (pp. 46-54). Lansing: Robert Smith.
- Stromberg, W. (1955a, July 24). No room for retarded. The Detroit Free Press, p. 8-A.
- Stromberg, W. (1955b, July 26). 1500 retarded wait. The Detroit Free Press, p. 1-A.
- Sumnar, W. (1906). Folkways. New York: Ginn.
- Superintendents of the Poor. (1872). Abstract of the annual reports. Lansing: W. S. George.
- Superintendents of the Poor. (1891). Abstract of the annual report. Lansing: Robert Smith.
- Superintendents of the Poor. (1902). Abstract of the annual reports. Lansing: Wynkoop, Hallenbeck, Crawford.
- Sutton, J. P. (1889). Imbeciles and idiots. Proceedings of the Annual Conference of the Association of County Agents and Convention of the Board of Corrections and Charities (pp. 101-105). Lansing: Robert Smith.
- Swainson, J. B. (1962). A program of progress: Messages of the Michigan State Legislature. Lansing: State of Michigan.
- Tarr, P. (Personal communication in an interview with R. L. Woell on February 13, 1985).
- Task Force on Mental Retardation. (1964). Meeting minutes. (Department of Mental Health. RG 70-73, box 24, folder 13). Lansing: Michigan State Archives, Department of State.

- Throne, J. M. (1979). Deinstitutionalization: Too wide a swath. Mental Retardation, 17, 171-175.
- Training Opportunity and Placement Project. (1968). (Department of Mental Health. RG 75-106, box 1, folder 1). Lansing: Michigan State Archives, Department of State.
- Trumble, L. (Personal communication, February 12, 1986).
- Tyor, P., & Bell, L. (1984). Caring for the retarded in America. Westport, CT: Greenwood.
- United States Bureau of the Census. (1950). Catalog of United States census publications, 1790-1945. Washington, DC: U.S. Government Printing Office.
- United States Bureau of the Census. (1975). Historical Statistics of the United States, Colonial Times to 1970, Part I. Washington, DC: U.S. Government Printing Office.
- United States Bureau of the Census. (1984). Statistical Abstract of the United States: 1985 (105th edition). Washington, DC: U.S. Government Printing Office.
- United States Children's Bureau. (1940). White House conference on children in a democracy: Final report (Publication 272). Washington, DC: U.S. Government Printing Office.
- United States Department of Education. (1980). Summary of existing legislation relating to the handicapped (No. E-80-22014). Washington, DC: U.S. Government Printing Office.
- Van Wagoner, M. (1941). Message to the legislature. Lansing: State of Michigan.
- Village of lunatics. (1848). The American Journal of Insanity, 4 (3), 217-222.
- Wagg, C. F. (1956). Selected correspondence with the ARC. (Department of Mental Health. RG 66-69-A, box 5, folder 1). Michigan State Archives, Department of State.

- Wagg, C. (1961). Memorandum to I. Polley regarding 1961 appropriations bill. (Department of Mental Health. Legislative files 1960-1965. RG 74-67, box 2, folder 1). Lansing: Michigan State Archives, Department of State.
- Wagg, C. (1962). Memoranda to Governor Swainson regarding 1962 legislation. Analysis of Bills--1962. (Department of Mental Health. RG 74-67, box 2, folder 2). Lansing: Michigan State Archives, Department of State.
- Wagg, C. F. (1964, March 16). Communication to Governor Romney regarding departmental organization. (Department of Mental Health. RG 74-67, box 2, folder 3). Lansing: Michigan State Archives, Department of State.
- Waldo, D. (1955). The study of public administration. New York: Random House.
- Weiner, D. (Personal communication in a speech to Community Mental Health staff on October 31, 1984).
- Weingold, J. (1956). A plan for state and community action. American Journal of Mental Deficiency, 62, 14-25.
- Wheeler, J. (1888). The legislature of 1887 and penal and pauper matters. Proceedings of the Conference of the Association of County Agents and Convention of the Board of Corrections and Charities (pp. 71-80). Lansing: Robert Smith.
- White, W. D., & Wolfensberger, W. (1969). The evolution of dehumanization in our institutions. Mental Retardation, 7, 5-9.
- Wieck, C., & Bruininks, R. (1980). The cost of public and community residential care for mentally retarded people in the United States (Project Report No. 9). Minneapolis: University of Minnesota, Department of Psychoeducational Studies.
- Wilbur, H. (1879). Status of the work. Proceedings of the Association of Medical Officers of American Institutions for Idiotic and Feeble-minded Persons, 3, 96-101.

- Williams, G. M. (1955a). Message calling on extraordinary session of the [Legislature on November 1, 1955. Journal of the Senate of the State of Michigan, Extra Session. Lansing: Speaker-Hines & Thomas.
- Williams, G. M. (1955b). Speech to the Joint Convention of the Legislature on November 7, 1955. Journal of the House of Representatives of Michigan, Second Extra Session. Lansing: Speaker-Hines & Thomas.
- Williams, G. M. (1961). A governor's notes. Ann Arbor: University of Michigan. Institute of Public Administration.
- Wilmarth, A. (1895). President's address. Proceedings of the Association of Medical Officers of American Institutions for Idiotic and Feeble-minded Persons, 19, 513-521.
- Wilson, D. (1975). Stranger and traveler. Boston: Little, Brown.
- Wolfensberger, W. (1972). The principle of normalization in human services. Toronto: National Institute on Mental Retardation.
- Wolfensberger, W. (1975). The origin and nature of our institutional models. Syracuse, NY: Human Policy Press.
- Wyman, H. (1905). The relation of the defective to the community. Proceedings of the Annual Convention of the Michigan State Conference of Charities and Corrections (pp. 30-33). Lansing: Wynkoop, Hallenbeck, Crawford.
- Zilboorg, G. (1941). A history of medical psychology. New York: W. W. Norton.