IX. A STUDY OF THE PROBLEM OF THE HANDICAPPED CHILD IN OREGON AND THE FACILITIES THAT ARE AVAILABLE FOR THEIR CARE, TREATMENT AND REHABILITATION.

Irene Alcock Krygier

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"The object of all help is to make help superfluous"

Submitted for

Bachelor of Science

Degree in

University of Oregon School of Nursing

by

Irene Alcock Krygier

June 1941

Part I

A Study of the Problem of the Handicapped Child in Oregon and the Facilities that are Available For their Care, Treatment, and Rehabilitation

Chapter I Introduction

This is a study which grew out of a need felt by myself in the study of the field of orthopedic nursing. Such a statement requires a demonstration of the relationship of the subject of orthopedics to the problem under discussion. The term orthopedics comes from the Greek word ortho meaning correct or straight and the word pais meaning child. Literally the study of orthopedics then would be the study of the straight child. Through usage it has come to denote the study of the "treatment of chronic diseases of the joints and spine and the correction of deformities.[1] The field includes both adults and children, conditions congenital and acquired; however, as the name implies it is primarily concerned with children or should be. I say should be, because statistics gathered at various times indicate that deformities are largely present at birth or are acquired within the first 6 or 7 years of life. For example, a survey in Chicago showed that of 1,531 cripple, it was found that 85% of the disabilities in those under 21 years of age were present at birth or occurred before the age of 6.[2] Wisconsin gave comparable figures in that 79% of those having deformities were found to be present under the age of 7.[3] I have been singularly interested in the phase of orthopedics which does confine itself to children. In this special nursing field I

1. Stedman's
2. Jesse L. Stevenson, A.J.N. Jan. 1, 1939
3. Ass. for disabled, Bull. 1 p. 20

found that frequently the child with the orthopedic disability presents many problems aside from his physical handicap. Problems which all too frequently act as deterrents in effecting cure or treatment for the child. These problems then are definite handicaps and range widely in character, including economic factors such as low income, no income, and transient work. Social maladjustment, broken homes, mal-nourishment, emotional problems, mental deficiency, lowered vitality, speech defects, deafness or impaired hearing, and blindness or impaired vision are some of the problems which constitute handicaps for children and which affect the therapy frequently of the crippled child. Those who seek to render professional aid to the orthopedically disabled child must know the various vacilities and agencies that are prepared to give the aid needed by these children in solving their individual problems or where complete solution is not possible at least partial adjustment of the therapy program to the childs other requirements. Since this paper is being written by one in the nursing profession, it seems probable that its content would be interesting primarily to other nurses, for nurses in all phases of the profession from general duty to public health nursing find that they frequently are called upon to enlighten parents or other interested persons concerning the possible avenues of approach to the care of the handicapped child. A nurse occupies a singular position with her professional training for she has had all of her sense precepto's sharpened through education and experience. Her eyes observe the tiny discrepencies of gait that might well go unnoticed, but which are little signals of distress for the child or adult who is crippled. Her eyes note the fluttering of the carotid pulse in the cardiac. To her,

the flush or pallor of the face has its significance, as also does the quality of dryness and maoisture, or warmth of the skin which she notices as she clasps a hand. A tiny infant that does not raise its arm, when startled by a noise close at hand would give the nurse cause for wondering whether there were a birth paralysis present. The child who is a behavior problem is not just a spoiled youngster to the nurse for she wonders whether the undesirable responses of the child aren't traceable to an emotional problem or feeling of insecurity that the child is unable to solve. A recurrent temperature or part with swelling and localized heat also have their significance to the nurse.

The nurse recognizes that her knowledge has served to increase her powers of observation of symptoms; so that she has learned to recognize many little distress signals which frequently go unnoticed by the lay person. Thus it is that a nurse is in a position frequently to refer cases for medical or medical-social attention.

Again the nurse because of her association with the physician and her close link to the lay person can often act as an interpretor, clarifying the implications of the doctors diagnosis. She is, one might say both professional and lay. As the interpretor, she frequently finds hereself in the role of advisor, being asked for information about facilities or agencies that are available for rendering assistance, or if the information is not sought, she through her knowledge that certain sources of assistance are available, can make suggestions to the family or to the responsible persons concerned with the case.

Since the nurse is in such a position of service she has a social obligation to fulfill in studying the various facilities available in her immediate community and state. A knowledge of the legislation which

which concerns itself with the handicapped child as well as knowledge of the recognized trends in approaching the care of the handicapped child would be of much value since she would bring this broader understanding of the problem to her work.

In seeking this information for myself as an orthopedic nurse and for others in the field of nursing who might wish to know how the problem of the handicapped child is being approached in Oregon, I have sought information from local printed material, studied current and past legislation and have visited or interviewed persons who were in a position to explain or demonstrate the phase of care with which they were conversant. To demonstrate the cooperation of the interested agencies in supplying care for the handicapped child I shall attempt to present illustrations from actual cases I have studied in Doernbecher Hospital, the Shriner's Hospital, and the Medical School Outpatient clinic.

Chapter II

SUMMARY OF HISTORICAL ATTITUDES AND TRENDS IN THE CARE OF THE HANDICAPPED

"The object of all help is to make help superfluous"[4]

How far man has come in his philosophy toward the handicapped to attain the insight that we recognize in the above gem. But how far behind has lagged our social attitude as reflected in our gains in this direction. Still we have much to feel gratified about when we have leaders in thought who can phrase our needs for us. An adequate and concrete statement of the needs of our society point up the direction our efforts should take.

Tribal preservation was the factor that determined largely the primitive attitude toward the handicapped person; that is, "the individual had a right to live within the group only so long as he was a useful member of their society and did not endanger the existence of the whole group."[5]

The practices of the various peoples seem to be adapted from the older tribal mores, for the "cripples of India were thrown into the Ganges", while the Babylonians refused admittance of anyone having a blemish to the court.[6]

Among the Hebrews the crippled priest could be fed and cared for through the offerings, although he was not permitted to officiate in the temple.[7]

On the grounds of eugenics, "the Greeks were accustomed to destroy their imperfect citizens."[8]

4. Introduction to Philosophy, Freidrich Paulsen, page 429
5. The Crippled and Disabled, Henry Hessler, page 14
6. " " " " " " " 16
7. " " " " " " " 17
8. " " " " " " " 17

The Romans did not practice infanticide until the corrupt days of the empire, although the laws even then indirectly discouraged it. "A father could destroy a crippled child after showing the infant to five others who gave their consent." Not infrequently such a child was rescued to become the slave of the rescuer.[9]

Christianity brought a new attitude, one of sympathy, to replace the "ostracism" that had been "meted" out before. This attitude did not dominate for long, however, and did not permeat the Church until later in its development.[10]

During the Middle Ages, the "cripple was the court jester, where he was regarded with ridicule and contempt"; however, this attitude was "harmless" in contrast to the treatment accorded the cripple during the "latter part of this period", for in the wave of ignorance, prejudice, and superstition that enveloped the people, the crippled were looked upon as "works of the devil or victims of the wrath of God." Needless to say, such a view toward those so unfortunate as to be deformed were excluded from all consideration of care.[11]

The only record of public provision for cripples until the Eleventh century was that in 590 A. D. when Pope Gregory included the crippled in his classification of the infirm and destitute.[12]

The first legislative provision for the disabled was made in 1530. The Twenty-second statute of Henry the VIII provided that the handicapped should be returned to the place of birth where he would be permitted to beg.[13]

The Twenty-seventh statute of Henry the VIII in 1535 ordered "that

9. The Crippled and Disabled, Henry Hessler, page 17
10. " " " " " " " 18
11. " " " " " " " 19
12. " " " " " " " 20
13. " " " " " " " 20

mayors, bailiffs, constables, and other head officers of towns, and parishes shall most charitably receive such poor creatures and shall succour, relieve and keep such people by way of charitable alms, and in such wise that none of them shall be compelled to wander and go openly begging."[14]

The fifth and sixth statues (1551-1552) of Edward VI directed the "collections of alms by commissions" for the impotent, feeble, and lame.[15]

In 1569 provision was made in London to take the "aged, helpless, sick, lame, or blind to either St. Bartholamew's or St. Thomas's Hospital."[16]

The Poor Relief Act of Elizebeth in 1601 consolidated the provisions of the previous poor laws and provided for custody of cripples.[17]

Although progress was slow, it would seem that Elizabeth's Poor Relief Law was the instrument which focused attention on the problem of the handicapped and was the incentive that brought the "organized social interest"of the 18th century. This evidenced itself in a desire to confine these people to monasteries for asylums. The primary consideration was seemingly to get them off the streets. There was no provision made for their proper care or education.[18]

The Nineteenth Century brought its quota of Poor laws and added its Factory Legislation: however, the status of the handicapped can be summed up in saying that they were "objects of pity". There was

14. The Crippled and Disabled, Henry Hessler, page 20
15. " " " " " " " 20
16. " " " " " " " 20
17. " " " " " " " 21
18. " " " " " " " 21

no thought nor hope of cure for them.[19]

The dawning of hope for these people has come with the rise of the science of orthopedics, and as more efficient means has been found to change the social attitude; however, repugnance and distate for the crippled still persists. Society has become humane enough to feel the obligation of caring for and educating its disabled members, and has evidenced this in its legislation and its provision for this work through appropriations, but society itself has not progressed far enough to overcome entirely a reaction of repulsion to all departures from the normal of mankind.[20]

The disabled must not only be cared for and educated in so far as is possible so that he may be able to fill an independent place in the social and economic life of society, but the attitude of the general public must be changed, so that the afflicted person will be accepted by them as a natural unit of the common society to which all belong.[21]

The contributions that have been made by and in Oregon to the solution of the care of the handicapped as reflected in the approach to the care of the Handicapped Child will be evidenced as this study progresses through the various phases of the problem.

19. The Crippled and Disabled, Henry Hessler, page 21
20. " " " " " " " 22
21. " " " " " " " 22

Chapter III

Historical and Legislative Basis of Oregon's Program of Care for the Handicapped Child

The story of Oregon's approach to the solution of care for the handicapped child is bound intimately with private charities which frequently stemed from the church in the community where the problem presented itself and made its need felt. We can imagine with little difficulty that the first problem in Oregon grew out of the pioneering the Oregon Country; that is, the provision for those children who lost father or mother or both during the perilous trip along the Old Oregon Trail. Doubtless kindly persons who had shared rigors of the journey, solved the problem by taking the orphaned child or children into their own home; however, as communities became established and organized, the problems which presented themselves were cared for usually by the church, since it represented the central influence of the community. As various charities were formed and required further monetary assistance than they were able to obtain through private donations, legislation was sought to recognize these activities as fulfilling a necessary function in Oregon's social set-up and thereby establish the right to financial assistance from the state. This early legislation tended to regulate their activities and to establish minimum standards for the maintenance of the institutions.

At present all activities and agencies which contribute to the care or assistance of handicapped children in this state are regulated through the State Public Welfare Commission which was established in March 1939. "The first step taken toward the creation

of a state wide public assistance program in Oregon was the appointment by the governor, in 1932, of a citizens' committee to pass upon applications for loans from the Reconstruction Finance Corporation and to study unemployment conditions.

"In February 1933 the legislature created the state and county relief committees for the purpose of cooperating with the Federal Government in supervising the expenditures of Federal unemployment relief funds in the state. The state relief committee was composed of seven citizens appointed by the governor. The county relief committees were composed of seven local citizens, four of whom were appointed by the governor and three of whom were members of boards of county commissioners or county courts. In general, the state relief committee was responsible for supervising the administration of unemployment relief throughout the state while the several county relief committees were responsible for the administration of work relief and direct relief."[22]

"In 1935 the scope of the public assistance was broadened beyond emergency relief to include care of persons who were unemployable..... The passage of the Federal Social Security Act in 1935 invited legislation by the state of Oregon in order to secure Federal financial participation in programs of old-age assistance, as well as, to the blind, aid to dependent children, child welfare services, and services for crippled children."[23]

"In March 1939 the legislature created the State Public Welfare Commission and the county public welfare commissions, replacing the state and county relief committees. The organizational structure of

22. Public Welfare in Oregon, 1939, Prepared by State Public Welfare Comm. Page 11

23. Public Welfare in Oregon, 1939, Prepared by State Public Welfare Comm. Page 11

the commissions remained the same, with the added provision that members appointed by the governor should serve for overlapping terms of four years each."[24]

"The powers and duties of the child welfare commission including responsibility for adopting reports; certification of private child-caring agencies, societies, and institutions; and approval of claims for state aid to private institutions and agencies for care of children."[25]

"Responsibility for the administration of a program of certification of private commercial boarding homes for children was also vested in the State Public Welfare Commission."[26]

Section 20 of the legislation setting up the Public Welfare Commission authorized County public welfare departments to accept custody of children and provide for the care, support, and protective services for children who are handicapped.

The Aid to Dependent Children Law provides support for needy children under the age of 16 who are deprived of parental support and who are living with relatives who are maintaining their own residence.

Aid to the Blind Legislation at first limited assistance to those over the age of sixteen; however the last session of the Legislature (1941) removed the age qualification for blind assistance.

Oregon Laws, 1939, Chapter 399 and Chapter 401 provides funds for assistance to needy persons and for the general administrating expenses of the state public welfare. This fund can be drawn on to the financial needs of the children who are not provided for under specific categories of the Public Welfare Laws.

24. Pub. Welfare in Ore., 1939, Prepared by State Pub. Welfare Comm. pp 11-12
25. " " " " " " " " " " " " 12
26. " " " " " " " " " " " " 12

The Services for Crippled Children, Capter 458 of Oregon Laws, 1939, designated and authorized the State Public Welfare Commission as the agency for administering the program. However, the 1941 Legislature transferred this Service to the auspices of the University of Oregon Medical School.

Chapter 421 appropriates money for certified child-caring institutions for the support and care of homeless, neglected, and abused children, foundlings and indigent orphans under the age of seventeen.

The 1941 Legislative session saw the passage of the House Bill 92 for state education of handicapped children. It "provides for the education of such children by school districts, state tuberculosis hospitals, Shriners' Hospital for crippled children, and Doernbecher Memorial Hospital for Children; "and" provides for "state aid to school districts furnishing such instruction and appropriating money therefor". The legislation provides for the repeal of such previous legislation as would conflict with it.

The Public Welfare Commission centralizes effectively all the efforts of agencies and institutions which are in any capacity concerned with the child in Oregon who requires assistance. Theoretically and in actuality this promotes more efficient service for them than has been previously possible under the decentralized control prior to 1939's Public Welfare Legislation.

Chapter IV

Scope of the Term the Handicapped Child

The problems which affect a child's welfare and happiness have been referred to, and in discussing their affect on the child I said that they represented handicaps. Possibly the use of this term should be explained. Again the authority of the dictionary must be sought in defining its meaning.

The word comes from an old game for forfeits in which the booty was concealed in the hand in a cap until the umpire called for it to be shown. From the homely play, the word handicap with reference to contests has been used to mean a method of artificially equalizing differences in native ability. In horse-racing, the horse with the advantage may be given a heavier jockey to ride or the horse at disadvantage may be given the lighter jockey or the favored place at the starting post.

From this use, the term handicap has acquired still another conotation and that is its application to designate the person who has a disadvantage which tends to interfere with successful living. Such a person is said to be handicapped. In the use of the term "The Handicapped Child" we will have reference to the factors calculated to interfere with the child's successful or satisfactory approach to living, whether the factor be physical, environmental, social, mental, or spiritual in nature.

In considering the factors which constitute handicaps for the child, the usual mental picture is that of a child with a crippling deformity; such as an atrophied extremity or cerebral palsy. If, however, we consider the subject a little longer we add to our mental list the child

with impaired vision or total lack of it. Then we recall the child with the speech impediment and loss of hearing. There are many other problems which also must be considered as handicaps for they fit our criteria of the term; that is, they interfere with successful living. Lowered vitality, mental disturbances, and emotional problems all take their toll from the child's total efficiency in meeting living situations satisfactorially. Some authorities suggest the use of the word "exceptional" rather than handicapped and would include one additional group, the gifted child. Their contention is that the child "may or may not be handicapped, depending largely on whether we train them to think of themselves as such". This "exceptionality" they say may be statistical or it may be unusual in the "sense that exceptional principles and techniques must be used in training them, that is, they may be excep tions to the rule so far as home, school and community routine are concerned".[27]

This study will exclude the problem of the gifted child, for this class of children does not tend to suffer in efficiently meeting living situations.[28]

For this reason, the term "Handicapped child", will be used rather than the more inclusive phrase "exceptional child" in referring to the problems presented in this study.

27. Wendell Johnson, Ph.D. Univ. of Iowa, "Education the Handicapped" Child Welfare Pamphlet #12
28. See page 1 paragraph 3 of this chapter.

Part II Oregon's Handicapped Child

Chapter V

Problem #1 The Child in the Migrant Family

Our nation is richly endowed with fertile land. That land gives the nation its food and supplies the food for other nations, but in the production of its crops it claims the services directly and indirectly of around half the population of our country. Some prosper on the efforts they expend in producing from the earth, others make a satisfactory living, while others can wrest only the barest livings from this toil. There is another section of people who serve the land and fail utterly; sometimes the factor operating to defeat them is nature's, i.e. the great droughts of 1934 and 1936.

Sometimes the land itself refuses to produce because it has been worn out by years of soil erosion and poor use. The Hebrews were instructed in their Mosaic laws to use the land for six years and on the seventh to let it lie fallow. Another means of letting the land rest, is to rotate its crops in order to restore to the soil the elements consumed by the crops individually. If the farmers of the so-called Dust Bowl of the Middle West had practiced the "rule of rest" under the scientific program of soil conservation as our engineers have conceived it, many of them would still be in possession of productive land.

The Machine Age with its huge tractors and other farm equipment has had its share in displacing the small farm tenant and worker. It is estimated that every big tractor put into operation on the farms displaced from one to five tenant families. Our industrial system was not prepared to absorb so many farm workers, consequently they, too,

were losers at the game of winning a living from the soil.

Foreclosures during the economic depression subsequent to the high of 1929 wrested more of the land from the small farm owner.

How many people have thus been squeezed out of their heritage of the land? We do not know; however, we do know that this year of Our Lord 1941 finds over 1,000,000 farm people wandering homeless on our highways. One third of that number are children. [29]

These people in their need sought the only means of earning a living they knew very much about - - farm work, seasonal farm work.

In the areas where farming has become an industry, where farms are rarely family sized, but consist of thousands of acres held by a business corporation and operated on the scale of big-business, the permanently employed crew is inclined to be small. This farming is well adapted to the regions producing specialty-crops; such as lettuce, cotton, hops, sugar beets, potatoes, cotton, and citrus fruits, for the only time that large numbers of laborers are required is during the harvesting of the crop. Out of this seasonal need for farm laborers has come the migration of whole thousands of families. The family lives in the vicinity of its temporary employment as long as the work continues, to earn what passes for a living and then it moves to the area of a new crop - a thousand miles is not an infrequent move for the Migrant familty to make.

The migration of the farm worker solves the problem of the corporation farms, but it does not solve the problem of how to make worthy American Citizens. It doesn't even make happy, healthy, decently nourished citizens. What of the children of these families? How are

29. "What we are to defend" Pare Lorentz from a reprint of McCall Magazines' A Report on the State of the Nation

they to acquire an education when they work with their parents in the harvest or remain too short a period in one place to enter school? How are they to learn the meaning of democracy or know the rich heritage of culture that our nation has acquired? How are they to learn that the law is for the protection of its nation's people? How are they to pass a heritage of a "strong mind in a strong body" to their children, when the conditions under which they have lived have frequently been far worse than a domestic animal from the standpoint of sanitation and housing? How are they even to possess for themselves the heritage of a "strong mind in a strong body" when the subsistence level is so low? The children are frequently mal-nourished in all the meaning of the term: too little of the right kind of food and too much of the wrong kind, i.e. partially spoiled fruit or unripe fruit.

Contagious diseases find a ready means of transmission under the usual conditions found in a Migrant camp. It was found that nearly every camp had one or more members with dysentery during a recent survey of the states which use extensive Migrant Labor.[30]

These have been but faint delineations of the picture and problem of the Migrant Family, enough to see though, that the states which have large influxes of migrant labor have a problem. Oregon is not one of the least in the use of this type of labor for the "pattern" of work here begins with "about 4,0000 laborers needed at Gresham from May to August for strawberries and raspberries. Then, the work may move on to Stayton where from July to September some 5,0000 pickers are needed for beans, or to the hop fields at Independence, where there is a demand for about 10,000 workers from August to September. From

30. Migrant Farm Labor: The Problem and some efforts to meet it. Bulletin from the Farm Security Administration, U.S. Department of Agriculture.

there, the migrant families may travel to Merril were 3,000 laborers gather potatoes from September to mid-November."[31]

How is this problem being met in Oregon? Most of its burden has been assumed by the Farm Security Administration Program. The needs of the problem have been approached through the FSA Migrant Farm Labor Camps and are "designed to provide temporary housing, sanitary, health and social facilities for dispossessed farm families and farm labor families following seasonal crop work."

The program includes Mobile Camps, a Permanent Camp at Dayton, Medical Care and Health Services, Employment, and Camp Management.

The Mobile units "provide accommodations for 200 families and sub-mobiles for 50 families each in areas where concentrated harvest operations last from four to eight weeks. A large wall tent provides a community center for children's play school, social and recreational activities. Water is piped through the camp and screened toilets are located conveniently throughout the camp area. Showers, laundry trays, hot water pressure system, clinic, office and electric light system are portable. Wooden platforms for tents are part of the camp equipment.

The Dayton Permanent Camp is located where seasonal work runs continuously over a period of about six months. Shelters and tent platform in the Dayton camp now open will accommodate 220 families and there are 47 labor homes occupied by families who have a semi-permanent employment pattern in the community and who have reasonable prospects of again establishing themselves on the land. Complete community facilities are provided through a general assembly build-

31."Mobile Camps For Migrant Farm Families" Bulletin Farm Security Administration, U.S. Department of Agriculture. September 1940

ing for meetings, church services, children's play school, school when necessary, dances and other functions; utility building with showers, toilets, laundry trays, ironing boards; clinic with small isolation ward; machine shop, modern sewage and garbage disposal plant.

Medical Care and Health Services: Clinics in charge of graduate nurses and attended by local physicians are established in all permanent and mobile camps. They provide medical care and health services for all migrant farm labor families in the camps and adjacent areas. Special emphasis will be placed on child health, prenatal care and immunization.

Employment: The state employment service maintains an office at or near each Farm Security Administration camp in Oregon. All camp families are asked to register with the State Employment Service, whose representatives survey local labor demands and direct all employment of families staying in the camps. All contacts between employers and employees are established through this agency and all hiring is done at their local offices." This practice would seem to protect the interests of both parties contracting for the work and furnishes a means of supervising and providing for decent living conditions for these people, which would be of definite benefit to the children for whom we feel the greatest concern.

Camp Management consists of a "manager and small staff, employed by the FSA, who are in charge of camp property, operations, applications, assigning quarters and maintaining law and order." As much as is possible "self-government by a camp committee elected by residents is encouraged. All social, recreational, religious, educational and resident welfare activities are in charge of the camp

committee and its sub-committees with appeal to the manager in case of adjustment or conflict with established policies. Each family head contributes two hours work per week to general camp maintenance." This feature of camp life furnishes an ideal means for educating the children in the camp to the fundamentals of cooperative democracy, by giving them the chance to experience the democratic community life that these camps afford.

There is still much to be accomplished in solving the problem of giving the child of the Migrant farm worker a feeling of security, an understanding of the meaning of democracy, a healthful environment, and a chance to acquire the education that is his right, even though the direction our efforts are taking seem to lead in that direction, now.

Chapter VI

Problem #2 The Mal-nourished Child

National statistics reveal the shocking fact "that 45,000,000" of our people are living below the safety line for food, houses, and health. Their earnings are "too little to feed, or clothe, or house themselves at a subsistence level, too little to guard against disease, starvation, and a life of misery."[32]

Where does Oregon fit into the picture of mal-nourishment? What percent of her children should be included in the category of living below the substenance level to protect their health? What efforts are being made to supplement obviously deficient home diets? Possibly some of the data obtained from W.P.A. School Lunch Program, the Portland City Schools, the Portland Fire Department Milk Fund, and the reports of the Federal surplus Commodities Corporation.

Portland Fire Department Milk Fund serves School District #1 of Multnomah County. The Fire Department furnishes two ½ pint bottles of milk daily to 1,256 children in 134 schools; these are all undernourished children who receive the milk.

Portland City Schools, which have no connection with Works Progress Administration lunches, have 35 schools which have their own lunch rooms operating on a Commercial Basis. They serve a total of 25-27 indigent children per week meals without charge. Are there only 25-27 children in Portland Schools who are unable to buy lunches or who are able to otherwise provide a nourishing lunch for themselves, or does the Fire Department's Milk Fund supplement the 1,256 malnourished youngsters diet adequately? That is a question for speculation for the writer has no information reach a decision as to the

32. What we are About to Defend, Pare Lorentz, from McCall Magazines reprint of a Report of the State of your Nation. page 3

adequacy or inadequacy of the free lunch program in the City Schools.

Over the State of Oregon outside of Portland the Works Progress Administration operates School Lunches in 162 schools (figures are for the school year 1940-41). It is not known how many children are served by these lunches; however, during the month of December 1940 a total of 215,177 meals were served and of this number 167,977 meals were served without charge. It would seem that in those schools having W.P.A. lunch rooms, the children would be obtaining a fine supplement to their home diet for the lung program operates under the supervision of State Consultant Dietitians who are well qualified for their positions.

In addition to the W.P.A. Lunches, the Federal Surplus Commodities Corporation of the U.S. Department of Agriculture supplies food for school lunches on the basis of needy or under-nourished children. This program is statewide in scope. This year, 145 schools have taken advantage of the Surplus Commodities and 5,566 children have been served through this medium.

What percentage of the schools outside of Portland supplement the mal-nourished child's diet with milk during the mid-morning and mid-afternoon is not known: it is resonable to suppose though, that a portion of them do through the auspices of Parent-Teachers Associations or other civic minded groups.

The Above Statistical material was compiled by Mrs. Ruby Hedblom, State Consultant for the W.P.A. Lunch Programs

Chapter VII

Problem #3 The Socially Mal-adjusted Child

or

The Child Guidance Program

The child who is socially mal-adjusted is primarily one who needs psychiatric assistance. Child behavior problems in conduct, in education, in habits, and in personality; such as temper tantrums, lying, stealing, destructiveness, fighting, anti-social activities, failing in school, poor grades, reading difficulty, slowness, enuresis, faulty food habits, soiling, masturbation, continual vomiting, aggressiveness, daydreaming, immaturity, irritability, lack of concentration, nervousness, speech defects, instability, excessive fears, convulsions, nightmares, inability to walk, and marked slowness of movement are usually considered to be symptoms of cerebral retardation, actual cerebral pathology or possibly incipient psychoses.[33]

Today we feel that the best therapy for children presenting these problems is preventive in nature. This attitude was not always held here in Oregon for the care of those whose symptoms became so marked as to be a noticeable deviation from the normal has "evolved" in Oregon as elsewhere through many steps. First was the "laissez faire" attitude - the insane roamed the country, second; was "Farming out" the insane into custodial care, third was "private institutional custody", fourth, "Custodial care by the state", fifth, "development of parole system", sixth, "establishment of receiving hospitals in the state asylum", and seventh, "Surveys of the insane in the state."

33. Child Guidance in Oregon Page 2, U. of O. Medical School 1937

"At the same time, the conception of the members of the medical profession has gone through similar stages: First, a "laissez faire" attitude "associated with witch-craft", second, the concept of the hopelessness" of mental disorders, third, the "belief that heredity was the chief answer to the causes of insanity", fifth, the belief that "insanity is chiefly due to environment", sixth, the "realization that many factors contribute to the cause of insanity and that organic changes, environment, heredity, and the general medical condition of the individual must all have a place in the approach to the patient's mental condition" and seventh, the "Preventive" approach, "stimulated by the development of public health". [34]

The preventive program in Oregon is based in the Child Guidance Program which operates under the direction of the University of Oregon Medical School. The medical staff is composed of "members of the faculty of the Department of Psychiatry in the Medical School"[35] who"correlate the medical, psychological, and social phases of child problems, working through the schools, and courts of domestic relations, child welfare departments, the family and other agencies dealing with behavior problems".[36] This work was being conducted in the Medical School Clinic limiting itself to children from Multnomah County, prior at 1937, at which time the Legislature passed an act appropriating 12,000 annually for extension of the Child Guidance Program to county units over the state.[37]

The establishment of these clinics is based on the desire of the county to avail itself of the Medical School's assistance in setting

34. "Child Guidance in Ore." State Child Guid. Program, U. of O Med. School 1937 pages 26 &29
35. " " " " " " " " " " 3
36. " " " " " " " " " " "
37. " " " " " " " " " " 10

up and maintaining the program. The Formal application must have the signatures of the representatives of the district-center school district, and the representative of the county medical society. It is desirable also to have the signatures of the Judge of Court of Domestic Relations, representatives of welfare and health agencies, representatives of women's and service clubs, others who are interested in the establishment of the clinic.[38] At present clinics are held during the year at Albany, Baker, Bend, Eugene, Klamath Falls, LaGrande, Marshfield, Pendleton, Salem, The Dalles, Grants Pass, and Jackson County.

Sources referring new accepted cases during the year of 39-40 were from "agencies (including social, medical, and health), Schools (both public and private), Juvenile Court, Private Physicians, Parents and Relatives, and Lay persons.

To give an idea of the extent of the work that was done by the Extension Clinics during the year 1939-1940 let me give some of the summary figures of the Clinic.

By the Psychiatrists:

a. Interview with or concerning patients		
1. for examination 223		
2. for follow-up contacts ...685		908
Physical Examination by local doctors.....		210
Psychological examinations by local or medical school psychologists.....		212

By case workers and teachers:

a. Social studies	214
b. Follow-up contacts 2670	[39]

The figures which are exclusive of Multnomah County would seem to reveal a high number of contacts by the Child Guidance program.

38. "Child Guidance" U. of Ore. Medical School page 6
39. Annual Report 1939-40 Child Guidance Extension Unit of Oregon pp. 2-3

Chapter VIII

Problem #4 The Speech Defective Child

The problems of the the speech defective child are frequently bound up with the emotional problems of the child. So closely is it related with the other problems of child behavior that the work in Oregon with the speech defective child is carried on as a part of the Child Guidance Clinic Program. Dr. Margaret Ringer, who is Clinic Consultant in Speech and Voice Disorders says in discussion of the occurrence of speech disorders with other behavior problems that "approximately one-third of the children she had examined in the clinic who had speech problems also had behavior problems, while approximately one-half were retarded at school and had definite learning difficulties".[40]

"With the opening of the school year 1938, the Medical School added consultive speech services to the Child Guidance clinic program for Portland and the state", until then the problem of speech correction was quite neglected in Oregon. There had been a limited attempt through the department of English in the University of Oregon; however, its staff and facilities were inadequate to carry more than a few of the "basic types of cases".

When the speech program for the state of Oregon was inaugurated in 1938 the problem was one of how to do effective speech work in spite of limitation in personnel and physical equipment. The same facilites were available in each district center for physical examination, for mental rating, and for obtaining the entire social history of the child as were mobilized for the psychiatrist; however, since the clinic met not oftener than three times a year in "any one center, only a few

40."The Speech Program of the Travelling Child Guidance Clinic of the University of Ore. Medical School" Dr. Ringer, 1940, Page 48

speech defective children could be seen at a clinic" in order to give time to explain the difficulty to the parents, the clinic case teacher, and the clinic social case worker. For this reason the emphasis in the speech program has been limited to individual case study rather than a "mass clinic". [41]

Special stress has been laid on educating the parents to the particular speech defect of the child and "to building up in the child's home a feeling of responsibility for cooperation in carrying out clinic recommendations. Diagnostic findings, and short and simple recommendations to the local staff for about three months of follow-up work, have been dictated into the clinic filed in the presence of the delegated clinic worker." The clinic worker conducts the child's program at home and at school and has the responsibility of maintaining the good relationship that has been established between the clinic, the school, and the home.

Special stress has been laid on diagnosing early symptoms of speech impediments to avoid the establishment of a "definite pathological pattern development." The emphasis is rapidly being placed on speech hygiene and prevention for this reason attention is concentrated on pre-school and first-graders in order to diminish "early learning difficulties defeloping on this basis," which would tend to "school retardation" and consequently to severe behavior problems.[42]

41. The Speech Program, etc. Dr. Margaret Ringer, Page 45
42. " " " " " " " Pp. 48-49

Chapter IX

Problem #5 The Blind or Partially Sighted Child

Many years ago a little girl recovered from a severe illness only to have lost forever the privilege of seeing the sunshine or the flowers or of hearing the patter of rain on leaves. Disease had taken from her the birthright of vision and hearing; however, her mother wisely secured the assistance of an able teacher, one who felt that time and effort might give the little girl the chance to learn to talk - someting she had forgotten how to do. That little girl was Helen Keller. Her accomplishments, despite her handicap, sound like a fabulous story.

Each year other little boys and girls are either born without their eyesight, lose it because of disease or accidents. Of course, the most important work for the blind is that of prevention. Good prenatal, care, the unfailing use of Silver Nitrate instillations at birth to cut down the incidence of Gonorrheal eye infections, disease prevention, and close attention to accident hazhards.

One of the most tragic cases I have ever cared for at Doernbecher Hospital was a little blonde-haired chubby girl about a year and a half-old who had lost the vision of both eyes from a gonorrheal infection. She was in for treatment to eliminate the infection from the area of the eyes, not for her sake, but for the sake of the other children and adults who might come in contact with her. The damage was forever accomplished for yer eyes. I have seen others who were infected a few days after birth from the mother despite the use of Silver Nitrate at the time of delivery.

The Oregon State Board of Health supplies all physicians and institutions who are concerned with the birth of babies with individual wax container's of Silver Nitrate. It is also a state law that this prophylactic measure be used. That is occasionally is not used may be due to oversight following a difficult delivery or poor condition of the baby at birth. Again there is the family physician who feels certain that he knows the mother so well that the possibility of a gonnorheal infection just doesn't exist and he feels that to administer $AgNO_3$ to her baby's eyesight would be a reflection on the mother. The loss of one baby's eyesight can never be compensated for, no matter how many mother's have been saved from the so-called reflection. The only reflection that I can see in the failure of a nurse or physician or other attendent at a delivery to administer $AgNO_3$ is carelessness or ignorance.

Conservation of eyesight holds a close second place to prevention. Proper use of the eyes under conditions of adequate lighting are important factors in this. Proper prescription of visual aids in the way of glasses by a qualified optometrist and frequent rechecks to ascertain the adequacy of the glasses are essential in conservation of eyesight.

The child who has lost his eyesight completely or to so great an extent as to hinder his education and to prevent his following the regular vocations which require eyesight become problems in education, and rehabilitation.

There are three methods by which this program is achieved in Oregon, One is the State School for the Blind at Salem. This school has children in attendence from the age of six to twenty-one years with the bulk of attendance occurring between the ages of nine to sixteen.

The average daily attendance during the biennium ending in 1936 was 67.75 children.

T heir high school instruction has been fully accredited which makes possible for those children graduating from the school to qualify for higher education if they wish. The number of Braille books available at the school has recently been greatly augmented through the interest of workers outside the school.

The Oregon Blind Trades School located in Portland accepts for rehabilitation from the age of fifteen. The work they are taught is such as caning of chairs, mattress making, broom construction, and other sheltered employment.

The Blind Assistance Act provides up to $30.00 a month for the blind or near blind. This is administered on the basis of need and until the last legislature was restricted to those above the age of sixteen; however, needy blind under that age are now entitled to assistance from this source.[43]

43. Twelfth Bienial Report of the Oregon State Board of Control pp. 182, 183, 184, and 216

Chapter X

Problem #6 The Deaf or Hard of Hearing Child

The child who is deaf or hard of hearing has little chance to recover from his disability since nearly all cases of auditory defects in children are of an hereditary nature. The method of rehabilitation for these children is instruction in lip-reading. Some children benefit from the use of Hearing aids - either a radio-ear or Penn-Cliff machine-instruments utilizing the principle of the radio with microphone. Something over 100 children are in attendance at the Oregon State School for the Deaf. These children are given auricular Training in an attempt to change "some of the students from deaf children to hard of hearing children." They are also given vocational training as well as academic training. The girls are instructed in the arts pertaining to homemaking; such as cooking, plain and fancy sewing, dress making, laundry work, and, in addition, typing and rug weaving. These girls can be used in sheltered employment by various factories and some of the large stores. One of the biggest department stores in Portland employs girls who are both deaf and dumb for inventory and preparation of the goods for merchandising, including labeling and application of price tags.

Boys are given instruction in printing, linotype operating, gardening, painting, calciming, woodworking and general carpentry work.[44]

44. Twelfth Biennial Report of the Oregon State Board of Control pp. 192-93

Chapter XI

Problem #7 The Crippled C hild

If there is such a thing as a fortunate groups of handicapped children, which I doubt exists, it must be the children who come under the State Crippled Children's program. Under the Shriner's Hospital program many children have been benefitted and still others continue to benefit from the expert sur gical, nursing, and physio-therapy care that is available through the Hospital and its Out-patient Clinic: (1) Attendance of the clinic average about fifty to sixty each clinic day. (2) The only qualifications for admission to Shriner's Hospital are financial need and certification by a local Shriner. (3) This has been one of the best private charities from the standpoint of assistance to children that we have had in Oregon. The percentage of failures to achieve an improvement in a child's condition who has been accepted for care in this hospital is negligable.

All possible types of orthopedic deformities have found their way to the hospital from the tiny infant a few weeks old with birth paralysis or club feet to the older child who has been stricken with infantile paralysis. The Club-footed baby has had his foot so straightened that later it could scarcely be known that he had ever had the deformity. The child with the Infantile Paralysis or Poliomyelitis comes to the hospital after the acute stage of the disease is over for muscle training by the physio-therapist either in the gymnasium or in the swimming pool, or both. Some of these children with poliomyelitis do not stay in the hospital but are brought in for their exercises in the swimming pool by their parents.

The children at Shriner's hospital who are able to study have a teacher each morning or afternoon and thus are able to continue their education while under surgical treatment. The recent legislation of House Bill 92 will provide additional funds for the educational program of this hospital, possibly more individual instruction for some of the cases which do not progress readily with the rest of the group. Of this number would be the child with cerebral palsy who usually is an educational problem owing to his physical and emotional instability.

Under the terms of the Federal Social Security Act, provision was made for funds for the Rehabilitation of the Crippled Child. The money was made available to Oregon when the State Public Welfare Commission established its Crippled Children's Division. During the year 1939 service was given to 1, 469 children. Although the last legislature placed this department under the direction of the Medical School its program and policies will continue as previously. This program is one of case-finding with thirty-one clinics at various centers over the state being held from one to three times a year. These clinics are held in county health units and are for the purpose of making a diagnosis. They are attended by an orthopedic surgeon and a State consulted Nurse in Orthopedics. After a diagnosis has been made, the eligibility of the child for care is determined. Those who are under fourteen and eligible are referred to the Shriner's Hospital for care and those over the age of fourteen are assigned to the care of one of the orthopedic surgeons in Portland. These physicians are well qualified for their position on the panel of the Crippled Children's Program, being some of the best in their field in Portland. Hospitalization is provided when necessary from funds from the Crippled Children's Department.

A few children are seen in the Medical School Out-Patient Clinic for such things as fractures and other disabilities which do not require hospitalization. Frequently though, these children are referred to the Crippled Children's Department or to Shriner's Hospital.

Infants and Children with Hare-Lip and Cleft-Palate or other disabilities requiring plastic surgery are admitted to Doernbecher Memorial Children's Hospital.

The Grout School in Portland for the child with cerebral palsy or other disabilities such as post-encephalitis which make ordinary school training impossible is making a promising beginning with this types of rehabilitative education and will surely achieve much for these children as the teaching staff and facilities are enlarged.

Volumes could be written about the work that each of these agencies have accomplished or are accomplishing, but as was stated in the beginning of this study, the purpose was primarily to acquaint with the agencies and facilities that are available for the Handicapped Child in Oregon.[45]

45. "Public Welfare in Oregon" 1939
State Public Welfare Commission

Chapter XII

Problem #8 The Child with Lowered Vitality - Tuberculosis, Anemia, Hernia, Syphilis, Epilepsy, and Heart Disease

Two of the attributing causes of lowered vitality - anemia and hernia - will usually yield respectively to medical and surgical assistance. Congenital syphilis marks its prey for death at an early age as arule, for it truly robs of vitality. The prevention in this case is the education of our mothers in the necessity of good prenatal care. A mother with a positive serology can give birth with an 85% chance of having a syphilis free child if she is placed under treatment early enough in her pregnancy. If the child of a syphylitic mother is born with syphilis and lives, it is frequently marked physically; either its teeth, mouth, or nose, Sometimes the only indication of its presence until adolescence is a marked lowered vitality or mental deficiency. Usually sometime before the eighteenth year congenital syphilis stops masquerading and becomes obvious in its symptoms. Concerning acquired syphilis, the Louise Home treats venerealy infected girls who are wards of the court.

Epilepsy is an hereditary disease and usually makes itself known by personality changes in the child with a gradual establishment of a definite pattern of convulsive seizures. These are controlled usually with one of the Barbital drugs, but the epileptic child is necessarily kept at home, out of school, or is institutionalized as the disease increases the amount of cerebral damage.

The cardiopathic child may have a congenital condition such as a

patent foramen ovale or it may be an acquired condition from rheumatic fever. This latter condition seems to be predisposed by the type of climate we have in the Northwest. The child with heart disease if able to go to school must forego active play and if the child is not strong enough to go to school must be content with light studying at home under the direction of the visiting teacher. The last legislature provided for the education of these children under its House Bill 92 for it included them in the definition of the Handicapped Child. The appropriation of state funds for the education of these children will be a great benefit for it will enable them to continue their education with a smaller expenditure of energy.

Tuberculosis truly "wrecks the vitality of youth" for statistics reveal that tuberculosis kills one out of every seven male adolescent who die and accounts for one out of every four deaths among girls. Again the problem involved is prevention through education and case finding. Oregon has made extensive use of tuberculin tests for location cases. During the year of 1939 the incomplete reports of testing gave 2,789 positive tests out of a total of 22,269 tuberculin tests. Of this number 6.3% were among elementary grade or pre-school children. Among high school children 10.5% were positive reactors. Chest examinations by "X-ray or floroscope revealed 276 cases of primary infection, 15 cases of active tuberculosis and 37 suspicious cases".

In 1939 the new University of Oregon Tuberculosis Hospital was opened on Marquam Hill in Portland which provides for 80 beds where surgical treatment can be done. It also is equipped with an out-patient clinic. The Eastern Oregon Tuberculosis Hospital added 50 beds through

building enlargement. There was an aggragate of 405 beds available at either the Eastern Oregon Tuberculosis Hospital or the Oregon State Tuberculosis Hospital prior to this time. There is also a full time agent employed for rehabilitation of tuberculosis patients. This program would effect the older adolescent rather than the younger child; however, since the preponderance of active cases among children occurs during the high school age it would seem that this program would be of definite value to the older tuberculous child.

Summary

There are many other services to children provided in and by the State of Oregon, such as day nursery care, foster home care, adoptive service, public and private orphanges and nurseries. These services are all conducted under the direction of the Child Welfare Services of the Public Welfare Commission; however, they represent services to children generally rather than for a specific type of handicapped child.

These agencies frequently; however, enter actively into the picture of children when they care for one who is handicapped and cooperate with the agency which provides the needed attention; such as Shriner's Hospital or Doernbecher Hospital. For this reason a list of them has been appended to the study.

Irene Alcock - Spy 3/c
June 5th 1941

Orphans and Foundlings

Albertina Kerr Nursery Home (infants - 5 years)

Rev. W. G. MacLaren
Pacific Protective Society
Dekum Bldg. Portland

Boys' and Girls' Aid Society of Oregon (birth - 18 years)

Mrs. Myrtle Dalziel
626 N. E. 29th

Children's Farm Home (5 - 18 years)

Mr. L. M. Gilbert
Corvallis, Oregon
Non-sectarian
Under auspices of W.C.T.U.

Jewish Shelter Home (3 - 16 years)

Mrs. Isaac Swett
1428 S. W. 12th Ave.

St. Agnes' Baby Home (infants - 7 years)

Father V. Moffenbier
Catholic Charities, Inc.
2051 S.W. 6th

St. Mary's Home for Boys (7 - 18 years)

Father V Moffenbier
Catholic Charities, Inc.

The Waverly Baby Home (Infants - 5 years)

Miss Lydia Schriner
904 Broadway Building

Children's Home (5 - 18 years)

Mrs. E. M. Parry
3415 S. E. Powell Blvd.

Christie Home for Girls (6 - 16 years)

Father V. Moffenbier
Catholic Charities, Inc.

Louise Home for Girls

Salvation Army White Shield Home

Volunteers Home for Mother and Children

BIBLIOGRAPHY

1. Facts about Crippled Children March 1940 Children's Bureau (Booklet)
2. Care of Poliomyelitis Jessie L. Stevenson, R.N. 1940
3. Public Health Nursing Jan. 1938 R. E. Wendall Arizona Plans for Its Crippled Children Page 31
4. Public Health Nursing Oct. 1937 F. L. Phoenix Wisconsin's Dual Program for the Crppled Child page 642
5. Public Health Nursing Jan. 1935 Martin F. Palmer The Speech Defective Child Page 22
6. Public Health Nursing Oct. 1937 Hulliboc and Harrison Minnesota Plans for its Crippled Children page 520
7. Public Health Nursing Aug. 1938 Mildred Meador A Public School for the Crippled Child Page 474
8. Public Health Nursing May 1938 Joseph B. Kelley Finding the Hard of Hearing Child Page 325
9. Public Health Nursing May 1936 Ruth A. Huntzelman Preparation for Orthopedic Nursing Page 302
10. Home Care of Poliomyelitis Patients May 1938 Jesse L. Stevenson Page 272
11. Public Health Nursing March 1938 Mary E. Bretz Needs of the Physically Handicapped Child Page 171
12. Public Health Nursing March 1938 T. Campbell Thompson, M.D. The Essential Features of Polio
13. Public Health Nursing March 1937 Ten Years of Orthopedic Nursing in Boston Page 150

14. A Curative Playroom for Crippled Children Page 379

15. Public Health Nursing Sept. 1935 Elsa H. Martens Special Classes for Crippled Children

16. Public Health Nursing Jan. 1937 Naomi Deutch Public Health Nursing in the Program for Crippled Children.

17. Public Health Nursing Feb. 1937 The Crippled Child in New York State

18. Public Health Nursing Feb. 1937 Marion Davis The Nurse in Accident Prevention

19. Public Health Nursing Jan. 1936 Country-wide Organization for Child Health Page 53

20. Preparing the Crippled Child for his Future April 1937 Mary Wysor Keefer Page 225

21. Public Health Nursing May 1937 Laura A. Draper A Curative Work Shop for the Crippled Page 280

22. A.J.N. April 1939 Hand Your Patient up while you Air his Bed. Josephine Johnson Page 375

23. A.J.N. April 1939 Earl T. Carlson, M.D. Understanding and Guiding the Spastic Page 336 and M. N. Grey, R.N. Nursing Care of the Spastic Child Page 367

24. A.J.N. July 1939 R.A. Heintzelman The Crippled Child and the Curriculum Guide Page 774

25. A.J.N. Oct. 1939 Doris Nelson, P.T. Crutch Walking

26. A.J.N. Oct. 1939 Margaret C. Klim The Drinker Respirator

27. A.N.M. April 1940 Sumner L. Koch, M.D. Treatment of Compound Injuries and April 1940 Hip Injuries and Nursing Eleanor B. Pittman, R.N.

28. History of the Doernbecher Memorial Hospital for Children Frank S. Doernbecher RJ25 March 1931

29. A.J.N. June 1940 Nursing Care in Poliomyelitis Carmeleta Calderwood, R.N. and June 1940 A.J.N. Poliomyelitis R. Clayton, M.D. Children's Hospital, Denver.

30. Oregon White Hose Conference on Child Health and Protection

Rj101 1932 History
D66r

31. A.J.N. January 1939 What is Orthopedic Nursing? Jesse L. Stevenson. R.N.

32. Public Health Nursing March 1938 Mary E. Bretz "Needs of the Physically Handicapped Child" Page 171