The Children's Home of Winnipeg

A Review of Recent Developments; from Orphanage to Treatment Centre

1950—1953

by

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ABSTRACT

This thesis is primarily a review of specific aspects of a residential treatment centre for emotionally disturbed children recently established by the Winnipeg Children's Home. The review covers only the first three years of operation of this centre and is not intended as a technical evaluation of the service offered by this new social agency. Rather, an attempt has been made to compare the facilities of the Winnipeg Children's Home with those of similar residential treatment centres in the United States. The specific aspects chosen for closer scrutiny are: (1) The Age and Sex Groups served, (2) Housing, (3) Personnel, (4) Diagnostic Study and Intake Procedure and (5) Treatment Programme.

As a basis of comparison a descriptive study of twelve residential treatment centres in the United States has been used. Five of these have been selected for closer study because they more closely resemble the agency being reviewed. Case studies, annual reports and other pertinent material from the files of the Winnipeg Children's Home has been used, coupled with the writer's first-hand experience as a member of the staff of this agency. Because residential treatment centres for emotionally disturbed children are a new tool in child welfare, an historical background of foster care for children has been included.

The question of qualified personnel to serve in a residential treatment centre has been of paramount importance in each centre studied. This pertains not only to social workers, psychologists and psychiatrists but also to house-parents who are key people in each project. To date, insufficient attention has been given to the training of house-parents; that is a matter which might well come within the scope of schools of social work. Further, in relation to the question of personnel, this thesis attempts to highlight the fact that in all communities, the best qualified social workers should be used in the area of family and child welfare. The study of twelve centres used as criteria in this thesis makes evident the shortage of psychiatric time so necessary to the successful operation of a residential treatment centre. This is true of the Winnipeg community.

The administration of the Winnipeg Children's Home demonstrated early in the life of this new project that financial costs of this service are, of necessity, high. This fact was confirmed by the study of twelve centres used as criteria. If a project such as that undertaken by the Winnipeg Children's Home is to be successful, the need has to be accepted by and made the responsibility of the total community. Finally, but of considerable importance to all communities is the tendency to invest funds in lavish buildings which can be useless without adequate staff.
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Chapter I

The Historical Background of Foster Care for Children

The welfare of children is universal in its appeal and has been a challenge to the community in each succeeding generation. Trygve Lie, former Secretary General of the United Nations used the phrase "The most irresistible of all causes" in outlining an appeal on behalf of children who had become the innocent victims of war. While these words were spoken in 1948 following the most devastating war in the history of the world, they are equally pertinent to almost any period of human history.

Most Canadians believe firmly that healthy family life provides the ideal milieu within which a child's personality can develop. It is generally agreed by experts in the professions of social work, psychology and psychiatry that the lack or loss of family life is severely and permanently damaging to a child. It is also generally agreed that every resource should be made available to maintain the child's place with his family wherever this is practical. In the history of child welfare legislation, the one exception is the situation where the child's life and welfare are affected detrimentally by his home, and separation from family appears to be the only reasonable solution.

Children, who, for various reasons, must be cared for away from their families are the subject of the present study. The basic welfare needs of these children are no different
from those of other children. The circumstance that separates them from other children is that society must protect their rights in lieu of their parents who cannot. The right of these children do not differ essentially from those commonly accepted for all children. A beautiful and simple standard is suggested by the following sections from the well known "Children's Charter":

I. For every child spiritual and moral training to help him to stand firm under the pressure of life.

II. For every child understanding and the guarding of his personality as his most precious right.

III. For every child a home and that love and security which a home provides; and for that child who must receive foster care, the nearest substitute for his own home.

IV. For every child full preparation for his birth, his mother receiving prenatal, natal and postnatal care; and the establishment of such protective measures as will make child-bearing safer.

V. For every child a community which recognizes and plans for his needs, protects him against physical dangers, moral hazards, and disease; provides him with safe and wholesome places for play and recreation; and makes provision for his cultural and social needs.

VI. For every child who is in conflict with society the right to be dealt with intelligently as society's charge; not society's outcast; with the home, the school, the church, the court and the institution when needed, shaped to return him whenever possible to the normal stream of life. " (1)

Most parents and members of the community at large would subscribe to the ideals expressed in the above quotation and sincerely attempt to achieve these ideals.

Examining these objectives more closely, it is evident that the love of parents and the security of family is regarded as the dominant factor in meeting the basic needs of all children. The dependent child is, therefore, one who has been deprived, temporarily or permanently, of his home and parents. Society has a special responsibility to see that these children receive imaginative and loving care, if it is to live up to these accepted objectives and recompense these children for what they have lost.

The Community's Approach to Meeting these Needs:

In the twentieth century, certain standards are expected in the community's care of dependent children. But these standards still vary widely in different communities, and the whole history is one of evolution in both the understanding and setting of such standards. The background of child-caring institutions can be covered for purposes of this study by a summary of five stages of development:

(1) Alms-houses, (2) Asylums, (3) Schools, (4) Homes, and (5) Social Agencies.

(1) Alms-houses: Alms-houses, as they were most frequently referred to, were used in England throughout the seventeenth and most of the eighteenth century. The first settlers in Canada and the United States carried with them this method of public care of the indigent. The alms-house was used not only for the indigent but also for the sick, the mentally ill, degenerates, criminals and other misfits. Children and adults
were housed together, often occupying the same room. The inmates were supposed to earn their care by "hand industry". Children were cared for by the older inmates. Their physical needs were neglected and the mortality rate was very high.

There were only two methods by which children might leave the alms-house, by adoption or by indenture. The adoption procedure resulted in prospective parents selecting children in random fashion from groups of children presented for their inspection. The lives of these children were, in effect, determined in roulette-wheel fashion. By the second method, indenture, the purpose was to make some individual or family responsible for the support and care of a dependent child. It was hoped that at the end of their indenture, which was in effect an apprenticeship, they would be employable, thus relieving the community of its responsibility. As may be imagined, the experiences of these children varied all the way from being abject slaves to the rarer one of being real foster sons and daughters.

Reforms came slowly due to vested interests, and because of the large numbers of children for whom plans needed to be made. It was not until the last years of the nineteenth century that this type of care was abolished.

(2) Asylums: The segregation of children from other groups of dependent persons into orphan asylums, and the setting up of institutions for deaf, blind or feeble-minded children were definite steps forward; though the management of them left much to be desired for decades.
While the name "asylum" has come to have a certain stigma today, when used in its primary meaning of "a sanctuary or a place of refuge and protection", it expressed well the purpose of the institution which it described. It was tangible evidence of the community's concern for its dependent children. Incidentally, the term "orphan" is a misnomer, as a large majority of the children, housed in these institutions, had one or both parents living.

The move towards segregation was healthy, but there remained many practices not conducive to good child welfare. Children were cut off from family ties, and emotional needs were disregarded. There was no individualization, and little regard for personalities.

The life of each child must have been conventional and somewhat stereotyped and monotonous. Many facilities began to be introduced into this type of institution. Schooling was not neglected, some medical care was given, and the children were encouraged in good work habits.

3) Schools: The concept of the institution as a school is not entirely new. Until quite recently, it was common for institutions to operate an elementary, and sometimes a secondary school, within their walls. Elementary education in institutions usually led on to apprenticeship or employment on a farm or in domestic service. The modern practice is for institutions to send their wards off the premises to public schools.

The introduction of greater educational opportunities into existing institutions did much to influence the status of
the child as an individual. In 1871, the State of Michigan passed a law establishing one of the first state public schools for neglected children. Under this law these children became wards of the government. They were placed with selected families while attending school. The school curriculum provided a fair elementary education, following which the state undertook to place each child in a suitable trade or pursuit during his minor years.

While other institutions of the day emphasized special education and training, they tended to be over-protective and to isolate the children from the world. This constituted a problem later for many children, who were unable to adjust to life successfully outside the protective walls of the institution. With the development of social work as a profession, dissatisfaction with this type of school care for children increased. Better means were found to provide education and training for children in their own homes and communities, and concern was directed to the emotional and social needs of these children.

(4) Homes: With the increased understanding of the importance of family life to every child, new methods of providing for children who had been deprived of their own family group, gained impetus. Foster family care, after considerable testing and refinement seemed to represent the most successful method of caring for dependent children.

During the period in which foster homes were coming into prominence, the institutions also began to change their
emphasis, and attempted to approximate family living more closely than was previously the case. The larger institutions were decentralized and broken up into cottage units with a "parent" for each group of children. Through this method, the institution attempted to care for children as they would be cared for in a foster home. In many instances the institution embodied the word "home" in its name. This change was a step forward and a practical move towards making institutions more homelike; in general, it brought greater comfort and happiness to the children under their care. Frequently, however, the word "home" was only a substitution for "asylum", with none of the emotional features of a home but with the same general programme of mass care.

The period which followed seems to have been one in which most institutions intensified efforts to break away from impersonalized asylum care. This, of course, did not occur overnight. In many instances, vested interests vigorously resisted the trend toward individualized care. Great gains were made during this transition and some of the basic tenets of present social work philosophy can be clearly recognized. These are exemplified in the increased emphasis on the value and dignity of the individual and in the recognition of the important place that personal relationships occupy in the development of children. The trend continued with these personal values being considered paramount. Foster parents were destined to play an increasingly distinctive role in the life of each child.
(5) **Social Agencies:** While it is true that there are still some child caring institutions whose boards and staffs cling to a programme of mass care, they are fortunately few in number. It is rare today to find an institution which does not have some working relationship with other social agencies in the community. This relationship may be in the form of selection and intake services for the institution, performed by an outside agency. Many institutions have qualified social workers on their staff.

The growth of the mental health movement, accompanied by the establishment of child guidance clinics and other psychiatric services in the community, has contributed greatly to the changing attitude within the institutions. The trend towards using educational facilities outside the institution has also brought institutional staff closer to another specialist in the community, namely, the teacher. The practise of allowing each child to follow his own religious beliefs has resulted in closer association between the institution and churches. Thus, the opening of the institution's doors to many and varied community services has resulted in the decentralizing of services from within the institution, and has helped to clarify the function of specialists and the part they can play in the institutional programme.

The following paragraph is quoted in order to clarify further the role of the institution as a social agency,

"Institutions come into the lives of children because of social problems and needs. The modern institution cannot escape the task of helping children with family problems or their own special needs, which are the reasons for children being in an institution. Social work is required along with the best in education,
medical care, etc. in order to help these children grow up successfully. Because it is called into being by social problems and has the responsibility of helping its clients reach satisfying personal and social adjustment, the institution is a social agency and needs to make use of social knowledge and skill in carrying on its work. Just as public assistance, family welfare and foster family care organizations are each a kind of social agency, with its special nature and function, so are children's institutions social agencies with many distinctive features." (1)

The Changing Emphasis in Institutional Care:

With the development of foster homes as the recognized method of caring for children out of their own homes, the number of children available for institutional placement fell sharply. Many institutions, both public and private, were compelled to close their doors by social and financial pressures. Further contributing factors were the increasing strength and numbers of child placing agencies and the introduction of social security programmes to assist children in their own homes. During the last decade, however, there has been a definite change in attitude regarding the basic philosophy of institutional care for children. As the profession of social work has gained more experience with both institutional and foster family care, there has been a major swing of the pendulum to a point where specialized institutional care is now regarded as an important resource in a good welfare programme. Foster family care and institutional

care each provide certain values which the other cannot offer.

The swing of the pendulum is, however, by no means complete. It has not swung back to the institution of twenty years ago but is gradually progressing toward newer types of group care. As the child-caring institutions of the past went through a transitional period in their development from large congregate institutions to the cottage plan, so the modern institution is being subjected to a stage of transition.

With the emphasis that is being placed on the individualization of the child that needs care apart from his own family, there is growing up in many communities various types of group care for children. Mr. John E. Dula, until recently consultant-surveyor for the Child Welfare League of America, lists the following varieties of institutions, —

1. **Congregate massive institutions** — a vanishing species.

2. **Cottage institutions** of the older type with thirty to forty children under one roof.

3. **Newer cottage institutions** — with eight to twelve children in each unit.

4. "Emergency" or "Temporary" shelters, too often filled with children who have remained for months and years because of deficiencies of boarding home and institutional programs.

5. **Detention homes**, usually operated by courts for the safekeeping of 'delinquent' children or of material witnesses, but too often the reservoir for children, even infants, for whom foster family resources are insufficient.

6. **Training Schools**, generally operated by the state, usually on a single-sex basis, for so-called 'delinquent' boys and girls, often isolated from the general stream of child welfare services and oriented more to an educational, custodial, or penal approach.
7. Free boarding schools, occasionally for upward of a thousand children, providing educational opportunities for children from low-income or broken families, but failing to identify themselves as social agencies either in philosophy or staffing.

8. "Baby folds" or infant homes, which according to competent psychologists, often produce permanently damaging effects on infants and young children.

9. "Boys Towns" or "Girls Ranches", which in certain sections of the country are spreading like a brush fire.

10. The study home or diagnostic centre, which almost always faces the problem of where to send the child for treatment or help once the diagnosis has been made, and whose existence often invites the placement of children whose study and diagnosis might have occurred just as well, if not better, in their own homes.

11. The maternity or shelter home, which I include because so many unwed mothers are older adolescents who are in conflict with their mothers.

12. The residential treatment centre, for emotionally disturbed children, which I include even though question may be raised of its identification as an institution or an entirely new and different species." (1)

A number of the above institutions are common in Canada; but, compared with the United States, specialized group care resources are scarce in Canada. Mr. Dula, referring to the United States, makes a further comment:

"When we recognize that probably one-third of our institutions are substandard and that another third should probably adapt their programs to the care of the more difficult children, we are frustrated in

our attempts to make thoughtful, positive, and constructive use of group care even though it would meet the child's needs better." (1)

Children who need Specialized Institutional Care:

Over a period of years the profession of social work has added to its knowledge of human behaviour and to its understanding of the needs of children. Social workers subscribe to the basic assumption that the average child requires, for its optimum development, individualized care in a normal home setting. There are, however, some children for whom we believe special institutional care may be preferable to foster care. It is now possible to be more discriminating and selective of those children who perhaps could benefit from specialized institutional care. It should be recognized, however, that there are some dangers in attempting a classification of children. In fact, the needs of individual children defy categorizing at times and overlapping can result. However, the classification which follows is suggested as being helpful in pointing up the needs of some children, -

1. Those children who have been hurt by rejecting parents and who, cannot, emotionally accept foster parents.

2. Children of school age who have satisfying ties with their own parents, which parents cannot maintain a home for them. These children may require temporary care but not new parents.

(1) Ibid.
3. Children who require temporary study in order to determine their particular needs.

4. Children in family groups so the family ties may be preserved.

5. Adolescents.

6. The child who has to be removed from the community because of delinquent behaviour.

7. The child with a physical, mental or emotional handicap for which he requires specialized treatment.

It is these children for whom a residential treatment centre may be the approximate resource; further examination of this will be undertaken in the following chapter.

**Method of Present Study:**

The purpose of the present study is to review the work of the Winnipeg Children's Home, taking account of the standards and principles set out in the Reid-Hagan Report of 1952, as outlined in Chapter II.
Chapter II

Programmes of Residential Treatment

In the process of searching for more effective methods of caring for and treating children who have developed personality disturbances, many specialized institutions have come into existence. These are often loosely referred to as "residential treatment centres". While these centres vary in their methods of approach, they all have one thing in common—the development of the team approach to individual therapy, or a therapeutically-designed living experience for the disturbed children who are served.

Residential treatment is a comparatively new innovation in child welfare, the idea for this method of treatment having been conceived in the early days of the child guidance movement. There is no well defined approach to the establishment of such a centre, and variation in programmes actually occurs only in setting and policy. The basic function of diagnosis and therapeutic treatment are fundamentally the same in all centres existing today.

The residential treatment centres existing today vary in many ways. Some include boys and girls, some are confined to one sex only. Age ranges differ, some separating pre-adolescents from adolescents, while some segregate the sexes when the period of adolescence is reached. Some centres work with so-called delinquent children with varying degrees of emotional disturbance; other centres completely exclude the
pre-psychotic or psychotic child. In some instances, treatment of the disturbed child takes place in what is known as an 'open' setting. In this setting, community resources outside of the agency are used. For example, the children may attend public schools, go to community churches and use the recreational facilities in the community. Other centres have a 'closed' setting. Here the centre functions as a complete unit within itself. Educational, religious and recreational outlets are provided for within the physical boundaries of the agency. Some centres combine both features of the 'open' and 'closed' setting. In such a centre, the privilege of community contact is considered a progressive step toward rehabilitation and return to community life.

During the past ten or fifteen years, interest has been growing steadily in this new type of institution and its significance in the field of child welfare. John E. Dula of the Child Welfare League of America describes the residential treatment centre as "a searchlight, fairly new and powerful, that is already locating and high-lighting many defects in our placement programs. . .".

He goes on to mention the following implications of the residential treatment centre,

1. It represents the acme of the renaissance of interest in, and activity of, institutions which has been evident since the 1930's. Residential treatment is the most specialized and highly refined of our present day institutional or group care programs for children.

2. Residential treatment is an outstanding demonstration of the team or multi-disciplinary approach in group care, bringing together the various disciplines of social casework, psychiatry, pediatrics, psychology, education,
anthropology, and others so that the child is aided not only by the specialist himself, but also by the total treatment atmosphere.

3. Residential treatment contains the potential capacity for long overdue research in such matters as the nature of emotional disturbance, the effectiveness of treatment, and the elements of good teamwork.

4. Residential treatment can be the most vocal and stimulating critic of our boarding home and other child welfare programs and of our community social services, including family casework services and mental health programs. Certainly this is true where the few centres are located, and even beyond its immediate area the centre is having an influence.

5. Residential treatment throws sharper light on what we have long been proclaiming – that foster children have the same basic needs as all children; but their needs are special too, arising in part from the trauma of separation from their own parents and the meaning of their parents whether dead, alive, active, or apathetic in their child's behalf.

While a variety of articles, pamphlets and books have been written on the theoretical base of such treatment centres, there has not been, until quite recently, any comprehensive description of their actual operation.

Principles of Residential Treatment Centres

As recently as July, 1952, the Child Welfare League of America published a descriptive study of twelve residential treatment centres in the United States which had pioneered in this field of child welfare. This study was carried out by Miss Helen Hagan and Mr. Joseph H. Reid, both specialists in this particular area, in the employ of the Child Welfare League of America. The study was made possible by the Field Foundation and is a definite step towards a broader knowledge and understanding of "residential treatment". In the view of the League, the survey was intended not as an evaluation but an expository
description; but the criteria used in selecting programmes to be included are of considerable relevance to further analysis.

1. The program should have as its major function the treatment of emotionally disturbed children in residence. Programs organized primarily for placement, custody, or care of feeble-minded children, spastic, the blind, and other similar categories were excluded, even though such programs might also attempt to treat emotional disturbance originating in these conditions.

2. It should be a program providing direct psychotherapy integrated with a therapeutic living milieu. Residential programs, depending solely on group living for therapy or, conversely, viewing the residence as a place where children are housed while being interviewed were to be excluded.

3. Centers were also excluded where there is no control possible over which children should be admitted.

4. The programs studied should be representative of the field as a whole." (1)

The complete study took place over a period of two years, and the persons who participated often lived at the particular institution being studied. This involved from one to three weeks of close observation, including contacts with personnel and reading records. The timing of the evaluation of a particular centre could not always be at the convenience of that centre. Thus, some centres were being reviewed during the periods of stress, such as occasions of staff turnover or internal re-organization. It must also be kept in mind that each centre developed independently of the other. Some stressed direct service to clientele, while others

focussed more closely on the training of professional staff and research. (It is important to note that of the twelve centres, seven are primarily medical and are administered by psychiatrists. The other five are social agencies, administered by social workers).

While costs are referred to in each centre studied, and are significant in relation to the type of programme offered, this aspect of the study is not stressed. In passing, it might be mentioned that all centres showed that the costs of treatment of emotional disturbance are of necessity high. Three of the centres are supported primarily by public funds and nine from private funds. Seven of them receive their major financing from community chests, federations and endowed funds. One was financed primarily by the patient's fees.

The study team emphasized in their report that a survey such as this cannot catch the tone, attitudes of staff, personalities, knowledge, experience and conviction which is so much a vital part of any treatment programme. The report recommends that this aspect of the study should at some time be transmitted to the field by those who are active in such a programme.

From this report, five centres have been selected for particular comparison. This selection was made because their programmes, by comparison and contrast, should produce the clearest picture of the present programme of the Winnipeg Children's Home. Here also some of the limitations of this study should be mentioned. It is not intended that this thesis
should attempt to evaluate scientifically the administrative or other professional techniques - casework, psychology or psychiatry - which are being used in the Winnipeg Children's Home. Because of the recent inception of the Winnipeg project, a study of this nature would be premature and would necessitate extensive follow-up material on the children served on which to base such an evaluation. A local committee of the Community Chest and Welfare Council of Winnipeg is at present working on an evaluation study in terms of treatment results. The outcome of this will be forthcoming at a later date.

Because each locality develops its child welfare resources independently, it is not always possible or practical to compare these resources. It is, however, possible to look at the development of the Winnipeg Children's Home and to compare this with the development of similar agencies in other communities.

To identify the five centres selected for comparative study it has been decided to refer to them as A, B, C, D, and E rather than repeating their names throughout. While the data used here are derived from the report of the study mentioned, each centre has submitted a review which has been appended in each case. As this thesis proceeds, it is proposed to highlight some of the statements brought out in each review in order to emphasize the fact that none of these centres consider the existing programme to be in any way complete.
To individualize the particular centres being described and to give an over-all general picture, information on the location and capacity of each centre as well as the age and sex of the children being served is assembled in Appendix A.

**Background of the Comparative Centres:**

From a comparative point of view it is interesting to note, at the outset, that all five centres have not been set up specifically as such, but have evolved, in the main, from institutions.

Centre "A" was founded in 1868 to care for orphans of the Civil War. Originally a dependency institution, it is an example of how an institutional programme can be revised in terms of new knowledge, to meet the needs of children. Psychiatric service was introduced in 1924 and a trained case worker was employed in 1929. In the latter year the children were transferred from a large congregate building to cottages. It was one of the first institutions to permit its children to attend community schools and to offer vocational training. Since that time its programme has continued to expand, adding further professionally trained staff and strengthening its treatment programme.

Centre "B", which is part of a large child-caring agency, started in 1907 as a resident nursery and temporary receiving home for pre-school and younger school-age children who needed physical care. By 1940 the policy had changed to include older children for longer periods, but the emphasis
was still on physical care. During the years 1945-1949, as a result of community study, planning and interpretation, a treatment centre was developed, offering individual treatment for emotionally disturbed children who cannot live in their own homes.

Centre "C" was founded in 1906 to serve as a model reformatory on a cottage plan. For many years the philosophy of this institution was that poor behaviour was punished and good behaviour rewarded. Over a period of twenty years there was a gradual shift in this philosophy. A part-time psychologist was employed in 1917, a part-time psychiatrist in 1927, followed by a part-time social worker, a year later. By 1935 psychiatric case work had increased, and a Child Guidance Clinic was established within the agency. This trend towards individualized treatment continued until the present time when residential treatment is being provided for children with personality problems who need a planned and protected environment.

Centre "D" grew out of a consolidation of several child-caring agencies, the first of which was established in 1893. The residential treatment service established in 1948, came as a result of board and staff recognizing the necessity of adapting part of the agency function to serve those children in their foster homes who needed specialized care and treatment.

Centres A, C, and D are so situated geographically that it is possible to use the resources of each
interchangeably as the need arises. This is an example of integrated child welfare resources within a given area.

While Centre "E" was organized in 1935 as a residential treatment centre, it had served a growing city for fifty years prior to that time. It gave shelter care to women and children on the basis of need and for indefinite periods of time. The treatment centre was founded following a community survey which established that the original need had ceased to exist, and recommended that a treatment service be provided for maladjusted children.

**Age and Sex Groups Served:**

There is general agreement among professional social workers that placement of infants and little children in institutions is not beneficial. There is indication that the five centres being examined adhere to this premise. The figures in Appendix II, compiled from the study, show that the typical age group being served by the five centres is the group aged nine to eighteen years. It should be borne in mind, however, that the figures for each centre relate directly to the physical setting of the particular centre and its intake policies. The physical setting and intake policies of each centre are discussed later.

The predominating age in the five centres is within the adolescent group. (Appendix A). It is not known whether this factor denotes a particular need among adolescents in each community at the time of the study, or whether previous emotional disturbance is accentuated by adolescence. The
critique submitted by Centre "D" makes the following comments regarding adolescents in their care.

"In starting the program we already had in our population a number of adolescents who, although we had had them for a long time, had not been able to profit by our foster home program and were not the type of cases which we would consider for any of our other facilities. Our initial planning, then had to focus around these difficult adolescents. Our hope was that as time went on, by using our more flexible facilities that we could use our units for younger children; younger children with personalities less rigid offer more possibility for a change. We find increasingly, however, that adolescents referred to us for placement, require a more controlled setting than our present units can possibly offer." (1)

Two other tables, Tables II(a) and II(b), compiled from the study are included as pertinent to this section of our examination. Table II (b) shows the numbers according to sex in each centre at the time of study. The number of boys far exceeds the number of girls. Again, this could possibly be related to the particular policy of a centre or may be the manifested need of the community. Table II(a) is included here because of its reference to age groupings, but will be referred to more specifically when treatment programmes are discussed later in this chapter.

(a) Housing:

Because residential treatment is a very new resource for children, housing standards adequate for this purpose have not as yet been established. When this new resource attains recognition as an integral part of a community's

child welfare planning, it is hoped that there will have been sufficient research into existing treatment programmes to provide an authoritative answer.

In the meantime, the few agencies that are attempting to establish residential treatment programmes are in many instances using a building or buildings which have been inherited from other uses. It has been demonstrated that many of these old institutions can be adapted to present day use. In many instances, child welfare agencies are providing "built-in" treatment services to meet the needs of disturbed children. It should be stated here that the provision of adequate housing of itself does not ensure a good programme. It is true that there are many backward institutions with elaborate buildings and equipment; conversely, excellent programmes have been carried on in outmoded buildings which, with a little imagination, have been made liveable. Current experience in residential treatment, however, indicates that the needs of disturbed children could be met more effectively in smaller units with appropriate furnishing and equipment.

It has been mentioned earlier that the five centres which are being examined were not built for this purpose. Through reorganization they have been adapted to meet the new function and have "built-in" or imported the necessary clinical services. A closer examination of these buildings discloses quite a variety of buildings and space. It is not intended that this examination shall in any way be an evaluation of adequacy or otherwise, but it is being included
here in relation to the programme being offered by each
institution. Because each institution is in a transitional
stage, buildings are from time to time remodelled to meet
changing needs.

Centre "A" is located in a newly developed
residential area on the outskirts of a large city. A number
of buildings comprise the centre and all are situated on thirty-
two acres of land. These buildings consist of an administra-
tion building, five duplex buildings used as ten cottage units,
a gymnasium which contains a swimming pool and serves as a
community hall and theatre, a chapel, and a laundry and
heating plant. Classrooms are located in the basement of the
chapel for those children who do not attend community schools.
Four of the five cottages are two storey, and house approx-
imately fifteen children with three, four and five children
to a bedroom. There is also an apartment in each cottage for
the cottage parents. The fifth cottage is only one storey on
the same general plan. It is used for the younger children
and because the rooms are smaller, accommodates a smaller
number of children. The acreage surrounding these buildings
provides ample play space.

Centre "B" is placed in a suburb of a large city in
a neighborhood which is an upper middle-class one. Origin-
ally there was one three storey building, erected in 1907.
Since that time a second two-storey building has been added
as well, as a cottage for the resident director. Schools,
churches, stores and other community facilities are close by.
There is provision in the main building for administrative offices and living quarters for house parents. Provision is also made in this building for interviewing rooms for the caseworkers.

Centre "C", it will be recalled, was built in 1906 as a model reformatory. It is situated about twenty-nine miles from a large city, on two hundred and eighty-eight acres of ground. There are twenty-six buildings and it comprises a small community in itself. Accommodation is, of course, available for the cottage parents and other residential staff required to live in. The director of the institution has a house on the grounds. The surrounding community is of mixed upper and middle-class families.

Centre "D" is affiliated with a large child-caring agency and residential treatment is one part of the service given by the agency. The programme is carried out in two units. One is a three storey building for boys ranging in age from thirteen to twenty years. This building is located in a business and middle-class residential district. The site was chosen deliberately as it was thought the district would afford greater acceptance for the children than entirely residential. The other unit comprises six apartment units and provides for girls, younger boys, and other boys who are unable to adjust in the larger unit.

The unit for boys is built in such a way that the boys can be separated into groups with a married couple in charge of each. Apartments are provided for the house parents
and interviewing rooms for the caseworkers. The grounds around this unit are somewhat restricted, but as community facilities, recreational and otherwise are used, this does not constitute a problem.

The apartment units are operated in a different manner and are located in different neighborhoods, widely separated from each other. Both houses are three storeys high with a nine-room apartment on each floor. Each apartment operates independently of the others. The house mother in each apartment is totally responsible to the agency for the physical care of the children and the management of the apartment. They employ their own domestic help and the group resembles a large foster family. Five of the six house mothers are married. The foster fathers have outside employment and function like the father in an ordinary foster home.

Centre "E" is housed in a large two storey building erected in 1919. There is a covered playground area adjacent to the building and an uncovered play area enclosed by a fence and occupying about half a city block. The Centre is located in a residential neighborhood composed of middle-class families. Community facilities are within easy reach and are used by the Centre. Provision is made for living accommodation for house staff required to live in. Administrative and casework offices are housed in the same building as the children.

(b) Personnel:

It would not be possible, nor would it be practical within the scope of this thesis, to list the number and variety
of personnel employed by the five centres being examined. It is to be expected that the larger centres would require to employ both professional and other staff in proportion to the number and type of children being served. Those centres affiliated with a child-caring agency have access to professional, clinical and clerical staff which would appear to reduce the number employed directly by the Centre. It is, therefore, not possible to estimate from the information given in the Report, the exact number of persons employed in each centre. Some very pertinent experience, however, relates to three groups (1) professional staff, (2) house-parents, and (3) maintenance staff.

1. Professional Staff: It has been stated earlier that each centre is under the direction of a graduate social worker. Several have additional educational qualifications, and many have social work courses beyond the Master's Degree in Social Work. All have had supervisory and administrative experience in the field of child welfare, and many of them have had previous experience in other treatment institutions.

In two instances, the resident director of the centre is a person who has graduated in an allied profession, i.e., Doctorate or Master's in Education. In such a case the resident director is responsible to and under the supervision of the executive director of the agency with which the centre is affiliated.

A quotation from the critique submitted by one of the larger centres will serve to highlight one of the main problems
in connection with residential treatment -

"There is no doubt that the greatest weakness of our program is the insufficient psychiatric time. We regard this as our number one problem. While at this time we have seven hours consultation time, plus fourteen hours a week for analysis of three children, we have been approaching a number of psychiatrists to get additional psychiatric time. It has been our goal to employ a half-time psychiatrist as a member of our staff so that a closer integration of the total program under psychiatric auspices is possible. In the meantime, we are trying to increase the psychiatric consultation time." (1)

The concern expressed in the above paragraph from the Report being studied, is common to all five centres, to a greater or lesser degree. The psychiatrists serving these centres are qualified child psychiatrists and with one or two exceptions are also analysts.

The use of the psychiatrist and the time available varies in each Centre. Centre "A" has three psychiatrists who give a total of seven hours consultation per week. His services are not used at intake except where the problem indicates this need. Centre "B" has one psychiatrist giving seven hours a week. In this time is also included service to the agency's adoption and foster home programme. The function of this psychiatrist includes diagnosis at intake, integration of the whole treatment programme, as well as some individual therapy where indicated. Centre "C" has three psychiatrists giving a total of thirty-nine hours per week for diagnosis and treatment on a consultative basis with some individual therapy. Centre "D" has three psychiatrists

(1) op. cit. - Reid-Hagan survey. p. 48
giving a total of twenty hours per week. This covers diagnosis at intake and consultative services shared by the agency's foster home and adoption programme. There are two hours extra given monthly for an in-service training programme. Centre "E" has one psychiatrist giving ten hours per month for consultative purposes. His services at the point of intake are determined by the nature of the problem.

The services of a psychologist are used in each centre. The question of supplying these services does not pose the same problem as that connected with psychiatric consultation. In the larger centres a psychologist is part of the staff. In the smaller centres this service is available in the community, usually through a child guidance clinic or on a fee basis.

The casework staff employed by the five centres under discussion are, with few exceptions, qualified persons. Many of those in supervisory positions have had advanced courses in psychiatric social work beyond the Master's Degree level. The majority of those engaged in direct treatment have a Master's Degree in Social Work. In one or two isolated instances, the Report records the employment of caseworkers with one year's graduate training in Social Work. Similarly, there are those on the casework staff who have had extensive experience, particularly in child welfare, while others have had no previous experience. In each of the five centres, adequate supervision is provided by qualified, experienced casework supervisors.
The responsibilities of the casework staff varies from one centre to another. In three centres the caseworker is responsible for individual psychotherapy with the children, in consultation with the psychiatrist. In one centre direct treatment is shared between the caseworker and the psychiatrist. In another, the caseworkers carry most of the responsibility for direct treatment with psychiatric consultation when indicated. The caseworkers in those centres affiliated with a child-caring agency have other responsibilities, such as the supervision of other caseworkers on the agency staff. Where volunteers are used in the programme, a caseworker supervises. In all instances, house-parents are in touch with the casework staff, although the caseworker may not be directly responsible for the supervision of house parents.

There is some slight variance as to the use of a caseworker's time. In some instances, those persons directing the programme believe that the caseworker's time should be devoted only to direct treatment of individual children. Volunteers and houseparents are used for such things as shopping trips, visits to clinics and doctors, and similar necessary parts of the child's daily life. Others believe that the caseworker can effect treatment while accompanying the child in his various activities.

The average case load is twenty children and each child is seen at least once every week. Where the need is indicated, a child may be interviewed more frequently.

Where not otherwise provided for, the caseworker is
responsible for the integration of the educational and recreational facilities within the community for the individual child. This is linked with the over-all treatment plan.

Because the caseworkers are responsible for psychotherapeutic treatment, this requires additional training. Two of the centres under discussion provide an in-service training programme for psychotherapy, conducted by the psychiatric consultant. This programme usually extends over a period of three years before a worker is considered fully qualified.

It is important, at this point, to clarify somewhat the term "psychotherapy", as it applies to the treatment of emotionally disturbed children. This is particularly necessary in view of the fact that social caseworkers are participating in this form of treatment. In so doing, it is not proposed to enter into an involved definition of psychotherapy. This would not be possible within the scope of this thesis. However, because the term is at times perhaps used loosely, and because this subject is a controversial one within the profession of social work, some clarification is necessary. For this purpose two quotations from an authority are very apt.

"Phenomenologically viewed, deviations in social adaptation are oriented, on the one hand, to environment and on the other, to vicissitudes in emotional growth. Both the structure of the environment and the structure of the individual personality are part of the problem. It is self-evident that the social worker cannot treat
social ills as abstractions, without adequate knowledge of people, since in the last analysis, social ills are expressed through the behavior of people; nor can the psychiatrist treat individual persons without knowledge of social patterns. Neither the caseworker nor the psychiatrist, as at present trained, is equipped technically to deal with the whole range of the problem. The total task, by its very nature, requires a fusion of the highest order of efficiency of the special skills of both professions."

"...... Psychotherapy is a function derived from the dynamic nature of the patient's problem, not a technique arbitrarily patterned to suit the conventional training of any single profession ....... Caseworkers, already trained in understanding social problems, can receive additional technical training in the interaction of the individual personality with social situations, and thus become equipped to perform certain levels of psychotherapy." (1)

As the Report on the individual Centres was examined, it was apparent that there is a need for a greater number of caseworkers equipped to function as part of a clinical team in residential treatment. This need was evident in the statements made by those persons responsible for treatment programmes. They indicated that there should be more frequency of psychotherapy and more intensive work done with parents.

Three of the five centres employ a social group worker. Two are graduates of a school of social work and the third is a student specializing in group work. All three have had practical experience. In the case of the student, she assists with the activities programme in centre "B". In centre "A" the group worker's function is integrated with the total

treatment programme. Her work is focused on the cottage group with the cottage parents as leaders. She is available to the cottage parents on a consultative basis for help in planning. The group worker in Center "E" functions in cooperation with the caseworker and house staff to provide the positive values of a group experience as well as an outlet for creative abilities. During an emergency situation she has functioned as a house parent.

The Report indicates clearly that other professional staff - teachers, tutors, pediatricians, nurses - are academically well equipped, carefully chosen for their personal qualifications, and subject to careful orientation to the treatment programme. This is particularly true where these persons are on the staff of the Centre.

2. House Parents: The Report gives considerable detail regarding the house parents employed in each centre, which it is not possible to pursue in this thesis. The most general principles worthy of note, which are applicable in each centre, can be discussed, however.

Predominating is the belief that house parents must be an integral part of the total treatment plan. Methods of effecting this integration vary in each setting. In many instances, house parents participate in conferences with professional staff and there is extensive planning regarding in-service training for house parents. The possibility of including house parents on this basis is enhanced by the fact that, with very few exceptions, those employed have had high
educational standards coupled with considerable experience in working with children. One Centre reports that the house staff employed are culturally and educationally equal to case work staff and salaries are comparable. Other Centres show house parents employed to have had full college education, some are formerly trained social workers, and some are at present in training for social work or other professions. All have had at least completed high school. The feeling is conveyed throughout the Report that the house parents are given almost professional status which helps towards developing a therapeutic environment.

In many instances, policies, rules and regulations for house parents are kept at a minimum and they are encouraged to develop their own programme within the cottage unit. All house staff are under direct supervision.

Of necessity, hours of work, vacation time and other personnel practices enter in. In some centres, house staff are subject to unionization. Hours of work vary according to the setting and the responsibilities involved. For instance, in one centre, house parents average 55-65 hours per week; in another 80 hours per week, and in one, the house mothers are responsible twenty-four hours a day, seven days a week. While at first these would seem to be long working hours, consideration must be given to the fact that, in some cases, the living situation allows for many hours of rest and relaxation throughout the day and, in all cases, they are compensated by provision of relief house parents. The usual relief period is two consecutive days each week.
The general practice seems to be the employment of married couples. Here again the function varies. In one centre the mother may be considered the employed house parent with the father employed outside the centre. The father may sometimes function as a parent in the cottage or may just give his services during the evenings and weekends in lieu of maintenance. In still another centre the living situation is such that both parents live and work with the children as with a normal family group.

In one of the larger centres, the Report includes the following statement which seems to sum up the place of the house parent in the total treatment programme.

"Cottage parents are seen as the focal people in the child's life in the institution. They are responsible for carrying out such functions as health care, shelter, clothing, feeding, discipline, teaching of good living habits (i.e., cleanliness, work habits); teaching and enforcing respect for law and order, property and the rights of others; participating in planning the use of the child's time within the cottage and in leisure time activities outside the cottage; observance of religious customs and ceremonies and establishment of good relationships of children to adults and to one another." (1)

3. Maintenance Staff: The staff employed in any centre is dependent on the type of accommodation, the extent of the programme, and the number of children being served. The persons employed covered a range of skills - cooks, maids, laundrymen, seamstresses, storekeepers, cleaning women, laundresses and janitors. All maintenance

(1) op. cit. Reid-Hagan survey. p. 152.
staff are under supervision. In the larger centres, the house manager (or manageress) spends the greater part of her time in supervision of staff, purchasing and planning. This person can also act as relief house parent when the need arises. In other centres, the director works individually in orienting resident staff to their work with the children.

Here again provision is made for integration with the entire programme. Staff are chosen for their personal qualifications, as well as for their particular skills. All maintenance personnel are oriented to the programme, and when they become involved in any type of relationship with a child, professional recommendations are made as to how the relationship is handled.

Hours of employment vary between centres. Generally speaking, personnel practices are carefully set down and, in some instances in the larger centres, union regulations are observed.

The Report conveys the fact that there is a considerable degree of flexibility among maintenance staff in relation to the programme. One centre reports that a house father spent part of his time performing janitorial service. This did not affect his relationship with the children.

(c) Diagnostic Study and Intake Procedure:

Diagnostic study and intake procedures are among the most important functions in each Centre. The Report covers each in considerable detail: For present purposes, its findings are summarized under the following headings
(1) referrals, (2) acceptance policy, (3) intake procedure, and, (4) parents' participation.

(1) **Referrals:** All five centres accept referrals from public and private social agencies. It is assumed that all other resources to help the child will have been explored when referral to the centre is made. Basically all centres recognize the importance of keeping a child with his family when it is possible, and it is believed that referral through a social agency helps to safeguard against unnecessary separations. It will be recalled that two of the five centres have developed residential treatment facilities as a part of their own agency. Referrals in this instance are, therefore, simplified.

Three centres accept voluntary applications from parents, but through a recognized social agency. This ruling holds also with referrals from schools, private psychiatrists, doctors and others interested.

Out of the five centres examined, four are associated with the Jewish faith. Being affiliated with Jewish child-caring agencies, their first responsibility is to Jewish children. It is noted, however, that in three of these centres a policy is gradually evolving whereby their services are being extended to non-Jewish children. One Jewish centre accepts non-Jewish children who seem to present special treatment possibilities. The percentage of applications accepted from outside their area of responsibility has to be restricted to twenty percent of their population. Another centre, where the policy is to accept Jewish children or
children of a mixed marriage where the cultural pattern is Jewish, is gradually extending its service to the community as a whole.

It is of interest to note that centre "C" gives priority to children committed from court. Historically, the responsibility of this centre, from the beginning, was the treatment of delinquent children and it has continued this service while building its new treatment programme.

(2) Acceptance Policy: While each centre is committed to its own particular policies, formulated on the basis of the programme being offered, all admit children who are emotionally disturbed, and who require the environment of a mental hygiene-oriented living situation on a twenty-four hour basis. These children's disturbance may be expressed through anti-social behaviour with hostility and aggressiveness. Others may show their disturbance through withdrawn and over-conforming behaviour.

In admitting these children, it is understood that they cannot be successfully treated within their own homes or foster homes. Most centres stipulate that the children must be able to live in an unlocked institution and participate in community schools and recreational activities. The programme of some is flexible enough to permit the admission of a child for study and diagnosis if treatment needs are not clear.

The admission of children to these centres is dependent to some extent on their physical and mental ability. Psychosomatic symptoms are recognized in some cases of asthma,
fainting spells and epileptic-like seizures, and children are not excluded because of this. While normal intelligence is stressed, it is recognized that I.Q. can be affected by emotional factors and that potentially children thus affected could be within normal limits. One of the centres examined bases its admission policy on dynamic rather than a diagnostic classification.

Children who are specifically excluded by the five centres include the following, who are variously described: feeble-minded, psychotic, physically handicapped, children with established organic epilepsy, gross brain damage, mental retardation not emotionally based, and those children who require restraint and firmer controls for their own protection and the protection of the community. Where a child is not accepted by the centre concerned, some responsibility is assumed to recommend an alternative plan so that the child may be helped.

(3) Intake Procedure: While the methods used in the actual placement of a child in any one of the five centres differs somewhat, each centre recognizes certain basic essentials. These are (a) the necessity for an adequate diagnosis in each instance followed by an intake conference, (b) cognizance of the psychological factors inherent in the group in which the child is to be placed, and (c) adequate preparation of the child for the placement.

This subject is of sufficient importance to include here the methods used by each centre.

Centre "A" - Referrals are evaluated at an intake conference
attended by the institutional caseworkers, regional or referring workers, group workers, the resident director, the casework supervisor and the psychologist. The psychiatrist is included at this conference when the need is indicated. This conference decides, on the basis of collective professional opinion, if the child requires residential treatment, his accessibility to treatment, and whether the Centre can meet his need. In smaller communities where diagnostic facilities may not be available, a child may be accepted on the basis of a social history leaving a diagnostic evaluation until later. Intake policies are kept flexible and, at times, a child may be accepted for a brief study period to establish a diagnosis. A diagnostic evaluation is made for all children within three months of admission.

Following the decision to admit a child, a programme of preparation for placement is started. The reason for placement is fully interpreted to the child as a means of helping him with his problems. When possible the child visits the centre to become acquainted before placement. The child is brought to the centre by the caseworker from the referring agency.

Centre "B" - This centre is affiliated with a child-caring agency. When an agency caseworker and supervisor decide that residential treatment is necessary, the case is discussed at an intake conference attended by the psychiatrist, the director of the centre and a therapist. Psychological and physical tests are not required if these have recently been
carried out by the agency. The decision to admit is based on the symptoms, the dynamics of the case, the current group in residence, and the staff situation.

The child is well prepared for admission. This procedure is flexible and is worked out between the caseworker, the foster mother, and the therapist. The child visits the centre before placement and is helped to understand the purpose of the placement. The agency caseworker withdraws and the therapist takes over when placement is completed.

Centre "C" - In this centre, the clinic director, a graduate social worker trained in psychotherapy, screens all applications. He may see the child and the parent. Following this, a summary is prepared for one of the weekly intake conferences, attended by the director, the clinic director, the principal, the assistant to the director, the psychiatrist and the casework supervisor. The decision to admit is based on the child's accessibility to treatment and his ability to participate. The matter of grouping of new admissions is an important consideration.

The preparation of the child is left with the referring agency and there are no preliminary visits to the centre. The children in the group may or may not know in advance of the newcomer.

Centre "D" - This agency is similar to centre "B" in that it is affiliated with the referring agency. When the agency caseworkers feel that residential treatment is necessary, the case is discussed with the director of casework and may then be referred to the psychiatrist for further appraisal.
The child may be seen by the psychiatrist as part of the diagnostic procedure, but this is not done routinely.

The unit supervisor participates in the psychiatric conference, after which a staff meeting is held with those who will be involved in treatment - the houseparents, casework staff and those who participated in the intake conference. Here also the matter of grouping is considered but not given precedence.

The child is prepared for placement, and several visits are made to the centre. He is told the reason for placement, as well as what the privileges and limitations will be, and he knows before placement that he will have regular casework interviews. In this centre the agency caseworker who has made the referral carries through the treatment.

Centre "E" - The suitability of a child for placement is determined through the pre-admission study. An intake worker is responsible for initial contacts. When it is decided that the child needs the service of the centre, he is assigned to a caseworker. This caseworker completes the intake study which includes several pre-admission interviews with the parent and the child. This caseworker usually continues with the child in treatment. The psychiatrist is called in at the time of admission if the problem warrants this. The final decision is an administrative one which takes into consideration the current problems in the centre, the needs of the child, and the treatment available. The
assignment of a caseworker is flexible, and changes may be made after placement if the need is indicated.

The child is carefully prepared for placement but the procedure is not formalized. The group is prepared for his coming, and he is introduced to the centre on the day of admission.

(4) Parents' Participation: The participation by parents in placement varies between centres. Two of the five centres believe that the parents should participate and encourage this, believing that the best chance for successful treatment of the child exists when the agency is able to work closely with the parent and the child. One of these agencies has a flexible policy which allows for one worker for each if necessary. The two centres affiliated with an agency subscribe to the above belief, but the inclusion of the parents is dependent on the agency's past experience with them. If they are interested, they are included in placement and treatment plans. The fifth centre believes that parents should be seen at least once a month, but this is not the usual practice, as many have been found to be inaccessible to casework. They have been known to other agencies prior to their contact with this centre. Many of the children in the care of this centre are adolescents. Because many of them will not return to their families, it is felt that the time of the caseworker should be used for the children.

Summary: The Approach and Treatment

The preceding summaries, especially those relating to
personnel, diagnostic study, intake procedure and the children served, give a preview of the general treatment programme of each centre. In fact, they constitute "treatment". The following paragraph quoted from the Report sets the tone and perspective of the treatment programme in all five centres,

"Treatment is a two-fold process combining psychotherapy and planned living. It is not confined to psychotherapy - to the interviewing process. It is based instead on the use of psychotherapy and the utilization of all the living experiences of a child in accordance with his treatment needs as understood psychiatrically. The objective of the treatment program is to integrate the living experiences with psychotherapy. This integration includes: (a) the kind of relationships he is to experience; (b) the intellectual stimulation to which he is to be exposed; (c) the groups he is to join; (d) the recreational activities in which he is to participate; (e) the worker he is to see.

All these are co-ordinated with what he needs and the strength he has as understood through continuous psychiatric treatment and evaluation. In order to achieve this objective, great care is taken in evaluating each child's needs and special efforts are made to individualize the program and to adjust and adapt the facilities of the institution in accordance with those needs." (1)

Rather than give a lengthy synopsis of the specific methods used by each centre in carrying out the above objectives, the methods common to all five centres studied may be summed up.

All centres use psychotherapeutic interviews conducted by qualified caseworkers in consultation with, and in some instances, directed by psychiatrists. The importance

of the residential staff and their integration into the total programme is emphasized in each centre. Every facet of the child's life is planned for in a therapeutic manner. Individualization rather than regimentation is the keynote. This applies to the child's education, recreational activities, care of his physical health, contacts with the community, and plans for his eventual return to the community.

In connection with education, there is an awareness that not every child can fit into and benefit from attending public school. While intensive use is made of schools in the community, provision is made for either educational facilities within the institution or tutoring on an individual basis. This is also true of recreation. If a child is not ready to use what the community has to offer, plans are made within the institution to take care of this.

The treatment programme within the living situation takes into consideration such things as individual clothing needs and what it means to each child; methods of control without which a child can develop a feeling of insecurity, and the possibility of a positive relationship with adults who are sincerely interested in him.

The integration of residential treatment in all centres is focused, from the point of intake, on the child's rehabilitation in the community. Towards this end, the institutional caseworkers and the referring agencies work together through frequent evaluation of the child's progress in treatment. This calls for a diagnostic awareness of the
total family situation. It is noted that in working with parents, some centres can apply to the court for guardianship of the child, if the parent is unco-operative or unable to make a suitable plan for the child. In those cases where a child is the ward of an agency, planning for discharge is, of course, in their hands. In some instances, therapeutic interviews can be continued with the child following discharge until he becomes established.

While each of the five centres examined serves a different community, geographically speaking, they have several points in common. In each instance, existing building were utilized and adapted to suit the treatment programme. Each centre gradually added qualified staff. In this connection, it is interesting to note that the common problems were inadequate psychiatric time and a constant turnover of house staff. Their intake procedures, with slight variations due to particular setting, are essentially similar. Children are admitted only when all resources within the community have been thoroughly scrutinized by a team of qualified persons and a decision has been reached that the child can best be served by removal from his own home or foster home. At this time also the treatability of the child is determined with special attention to the group already in the treatment setting. The treatment programme of each centre is similar in that recognition is given to the fact that treatment comprises the total social climate of the centre.
Chapter III
Child Care Programmes in Winnipeg 1946 - 1958

It is now possible to apply the experience of five comparative centres to the initial experience of the Children's Home in Winnipeg. The new programme of this agency will first be viewed against the history of how the City of Winnipeg became aware of this particular problem.

A key document in this recent history is the Survey of Child Care and Protection, made in Winnipeg in 1942. This Survey was conducted by the Canadian Welfare Council at the request of the Canadian Welfare Board (Community Chest) of Winnipeg. This Survey disclosed two main basic weaknesses which the community would have to eliminate if a modern structure was to be soundly based and developed to meet the standards of present day social work. These weaknesses were

n (1) The absence of adequate service of child placing in family homes, the overwhelming preponderance of institutional care ...... and the absence of proper correlation of function between these two types of care;

(2) The inadequate standard of personnel and the almost total lack of trained leadership and staff. " (1)

In the light of present day standards, the situation in Greater Winnipeg was obviously out of line:

(1) Report of the Child Care and Protection Survey of Winnipeg, Manitoba - 1942
of the children in care, only thirty-two per cent were in foster homes and sixty-eight per cent in institutions.

Exploring the matter further, the Survey disclosed that the following facts contributed to this situation.

1. Practically all admissions of children to Winnipeg's child-caring agencies were controlled by the Children's Aid Society and the Children's Bureau. The Bureau was only nominally under the direction of the Children's Aid Society and was a separate entity and was a member, in its own right, of the Community Chest. This Bureau had been created following a survey in 1925 "to introduce order in the intake and discharge programme in the child welfare field in Winnipeg...." It had served a useful purpose for several years, but its peculiar organization prevented its development along acceptable lines. The Board of the Bureau was almost solidly composed of members who definitely represented institutional interests. At the time of the 1942 Survey, the Bureau controlled practically all admissions of non-ward children, which comprised forty-six per cent of the child care population.

2. The financing of the care of dependent children loomed as a large factor. Financial considerations had greatly outweighed the social considerations, if they had not entirely displaced them. For example, to obtain municipal assistance for children in the care of social agencies, it was necessary that they become wards
of the Children's Aid Society.

3. The Survey highlighted the fact that child-caring arrangements in Winnipeg at this time were the reverse of the generally accepted practice - "A normal home for every normal child" had become "An institution for every normal child in care". Instead of specialized institutions handling the children unsuitable for foster home care, the foster home service was handling the children not considered suitable for the institution.

4. In Winnipeg religious organizations played a dominant role, especially in the child-caring institutions. Vested interests and endowments would constitute some difficulty in establishing a sound programme of child care.

This was the general child care situation in Winnipeg when this survey was made over sixteen years ago. The chief recommendations to remedy existing defects were,-

1. An expansion of foster home care.


3. Abolition of the Children's Bureau. Child placement to be the responsibility of the Children's Aid Society. Until the institutional programme was stabilized, a non-ward placement committee would function under the Children's Aid Society to control institutional placements.
4. Re-alignment of the boundaries and areas of responsibility of the Winnipeg Children's Aid Society and a similar Society adjacent to Winnipeg, both correlated under the Provincial Department of Health and Welfare.

In implementing the above, the Survey made specific recommendations in connection with the religious aspects of placement - particularly pertinent to this area. Recommendations were also brought forward in connection with the re-allocation of financial responsibility. Heretofore, the Community Chest of Winnipeg had borne a disproportionate share of the cost of non-ward care. Specific recommendations were made regarding such matters as care of non-resident children; unmarried mothers; children with mental problems; adoptions. Finally, a major recommendation concerned the need to provide psychological and psychiatric services which at this point were wholly inadequate.

Through this extensive Survey, in which a great part of the community cooperated, the City of Winnipeg set itself the enormous task of re-organizing its child welfare services.

In the short space of five years, great strides were made in the expansion of a foster home programme. The Children's Aid Society increased the number of its foster homes and completely re-organized its staff, employing several trained social workers. In other Chest agencies and the Provincial Department of Health and Welfare, corresponding changes and developments took place. Other community action included the establishment of a counselling, guidance and visiting teacher service in the schools as a part of an expansion programme of the Child Guidance Clinic of the
It is of interest to note that the establishment of a School of Social Work in the University of Manitoba became a reality as a result of the personnel needs which this Survey disclosed.

The emphasis in all work with children was now on prevention and this was probably indicative of social progress and a changing philosophy within the community.

At the time of the 1942 Survey, Winnipeg, through its Community Chest and the Winnipeg Foundation Fund, was supporting six child-caring institutions. These institutions were giving care to normal children, some mental defectives, some children who would likely need care for several years, and some who needed only temporary care. As normal children were moved to foster homes, it became apparent that the future use to which these institutions could be put, needed revision. Serious consideration would also have to be given by the Community Chest and the Winnipeg Foundation to the financial implications of this developmental period of perhaps ten years. Financial support for an expanding foster home programme would be needed, while concurrently some congregate institutions would have to be supported and with a dwindling population.

The Second Survey — (1946)

For this reason, in January, 1946, the Winnipeg Council of Social Agencies undertook a study of the child-caring institutions in the community with the purpose of recommending what the future function of these institutions
was likely to be in the total child welfare programme.

It is worthy of mention, at this point, that it was from within the institutional boards and staffs that the need for this study was made evident. The institutional personnel felt that they must be prepared with the right kinds of programmes and staffs to meet changing needs in the field of child care.

This study of child-caring institutions in Winnipeg was conducted by Morris Mayer, Ph.D., Resident Director of "Beliefaire" in Cleveland, Ohio, one of the outstanding residential treatment centres in the United States.

From the beginning, Dr. Mayer felt that his particular task was not so much that of a research person as that of an interpreter to the lay and professional child care field. He felt that "the survey would have little value if it were not understood and approved by those people who would be responsible for implementing the recommendations. He had to show clearly the role of institutions in a child-care programme and the type of staff, building and programme needed to enable them to play the role in conformity with the best known principles of child care."

For these reasons, much of Dr. Mayer's time in Winnipeg was spent talking with board members and staffs of child-caring agencies and institutions, and with related services in the community. An intensive analysis was made of data compiled by these child-caring agencies and institutions, regarding such matters as the number of children of different
religious faiths, the sexes, age groupings, length of time these children had been in institutions, the reason why they were given institutional placement, as well as the general use being made of the institutions by the various child placing agencies.

While it was intended that this survey should cover only those institutions supported by the Community Chest, it was found that the total community view of child-caring institutions would not be valid unless all institutional facilities were included.

Throughout this Survey, Dr. Mayer repeatedly emphasized certain basic principles common to all modern child welfare programmes. The following excerpts from his report bear repeating here. These principles were laid down at the White House Conference on Child Welfare by the United States Children's Bureau in 1919.

"The fundamental rights of childhood are normal home life, opportunities for education, recreation, vocational preparation for life, and moral, religious and physical development in harmony with American ideals, and the educational and spiritual agencies by which these rights of the child are normally safeguarded." (1)

Further fundamental principles of institutional administration were emphasized.

"1. Thorough investigation before receiving a child.

2. Co-operation with other agencies that are or should be interested.

3. Maintenance of the child's community contacts and his relationship with his own family.

4. Continual efforts toward the re-establishment in the child's own family home or placement in a foster home under healthful conditions." (1)

This study of 1946 made several practical recommendations as to the specialized jobs which child-caring institutions in Greater Winnipeg might undertake. While the subject of this present study makes it impractical to cover all these recommendations in detail, it perhaps would be helpful to mention the more general recommendations which have a direct bearing on the Children's Home and are pertinent to the evaluation being made in this present study,

Some of these general practical recommendations are as follows, —

"1. That in future, child-caring institutions be located within communities in order that maximum use may be made of educational, cultural, recreational and other facilities.

2. That no child be accepted into any Greater Winnipeg child-caring institution on direct application of the parents, but that all such applications be referred to the appropriate social agency in order that the reasons for such request and possible alternate means of helping the child may be explored; that only admission requested by an accredited social agency be considered by the institution. Until a re-organization of the intake machinery is completed all non-ward admissions from the Greater Winnipeg area should be approved by the non-ward placement department of the Winnipeg Children's Aid Society.

(1) op. cit. p. 7
3. That each institution make arrangements for the employment of a case worker.

4. That an Association be organized by the Council of Social Agencies to promote further staff training and education among all institutional workers and that in-service training of institutional staffs be provided immediately and arrangements made to send personnel away for further training whenever possible.

5. It is important that the total programme of the institution be designed to help the child requiring that institution's care; and essential that it be an integrated programme, that all services and activities be soundly developed and sufficiently flexible to meet the needs of the individual child. ......... no one staff member can carry through a treatment programme unless adequate facilities are available and unless all institutional personnel are working co-operatively together." (1)

The above general points culled from the Report of this Survey seem to summarize the main reasons for the existence of any child-caring institution. The first point highlights the modern trend in institutional care of children, referred to in Chapter I, i.e., against isolation from the community and in favour of helping the child become part of the community.

The other recommendations emphasize the more specific aspects of a good institutional programme - better intake procedure, the addition to the staff of professional social workers, and more adequate training for institutional personnel.

Buildings and Facilities:

It is not within the scope of this present study to trace in detail the history of the Children's Home of Winnipeg to its present development as a residential treatment centre. The history of the Children's Home of Winnipeg is synonymous with the growth of the City of Winnipeg and would make an interesting study in itself. But a summary is helpful to what follows.

In the year 1884 the Children's Home met a real community need when it established the first shelter care for deprived children in Winnipeg. Over a period of sixty years this home expanded until at one point its population was over one hundred children in a large congregate institution, situated on several acres of land on the outskirts of Winnipeg.

As time went on, the newly established Children's Aid Society in Winnipeg required temporary shelter facilities for their children who awaited placement or other planning. The Children's Home contracted to supply this shelter care to the Children's Aid Society. As the foster home programme developed, after its establishment in 1942, the population of the Children's Home decreased, and the Board of the Home began to question the wisdom of maintaining such a large institution for the work needed. This thinking on the part of the members of the Board of the Children's Home, however, was also indicative of acceptance of a changing social welfare
philosophy.

In 1945 an opportunity arose to sell the Home buildings, which could be used as a small hospital; after consultation with the financing and planning bodies of the community, this was done. The money realized from the transaction was placed in a special building fund with the thought that after World War II, a new Home would be built in conformity with up-to-date ideas of child welfare planning.

This situation left the Children's Aid Society without shelter facilities at a time when considerable reorganization was going on within the Society. Until such time as they were able to enter their own permanent field of care, the Children's Home Board, with their long experience of administering an institution, and with some available staff, agreed to operate two Receiving Homes for the Children's Aid Society. This plan continued from 1946 to 1949.

The Children's Home Board played their part in the new foster home programme; the institution which they had operated had been sold; their funds were intact; and they were willing to undertake a worthwhile project in the newly focussed programme for child caring institutions. The Children's Home was one of the institutions covered by Dr. Mayer's Survey in 1946. What specific suggestions were made as to a possible programme for this institution?

In the earlier stages of this Survey, the Children's Home Board had indicated its desire to give up shelter care
and establish an institution for the care of Protestant girls separated from parents. Reference has already been made to the dominant role played by religious bodies in Winnipeg's child-caring institutions. The Children's Home was for many years the only institution in Winnipeg which cared for Protestant children exclusively. The results of the Survey of 1946 showed that there would continue to be a need for a small institution of this kind for girls of the Protestant faith. It was indicated that these girls would need a similar type of service to that proposed for another institution which cared for boys, - a programme of treatment for the disturbed, pre-delinquent child. It was thought probable that both groups would be from twelve to sixteen years of age, and would come from "broken homes". Some of these children would require intensive institutional treatment prior to placement in a foster home. With others, unfortunately, institutional care might be tried as a last resort, care in their own homes or foster homes having failed to help them. Some thought was given to the possibility of the amalgamation of the administration of these two institutions.

It was pointed out in the report of this Survey that perhaps the Children's Home should be dealing with the most difficult group of disturbed children. The community, says the Report, -

"will not except a high percentage of success with this group, but we do hope that these institutions will become laboratories for research into the
behaviour difficulties of these deeply disturbed children." (1)

The proposed integrated programme for child-caring institutions in Greater Winnipeg, as set down in Dr. Mayer's survey report, was all inclusive and when implemented would provide many valuable resources to those working in the field of child welfare.

The Board of the Children's Home wished to be part of this newly focussed programme. In consultation with the Council of Social Agencies, the development of adequate resident treatment facilities for disturbed children was suggested. Accordingly, after much study and discussion of the project with local experts in the field of community planning and financing, with family, child welfare, medical and educational people, as well as those working with similar projects elsewhere, the Board of the Children's Home undertook to establish a treatment centre for emotionally disturbed adolescent girls.

The New Programme of the Children's Home Of Winnipeg:

The Children's Home of Winnipeg opened its new centre in December, 1950. In this Centre would reside a maximum of ten girls, carefully selected and presenting such problems in emotional adjustment in their own homes or foster homes as to indicate development of more serious social problems in the future. This group would be representative

of those with whom earlier efforts had been made at treatment within their own family groups or in a foster home, but where for many reasons this had not been successful.

**Housing:** After consultation with community welfare planning groups and considerable study of the subject, the Board decided to rent or buy a suitable building in a desirable location.

Many large old houses were inspected by the Committee responsible for this selection. Their choice was a twelve-roomed house located in a working-class residential neighborhood close to the city. This house was formerly a single family dwelling. It is well constructed and in good condition. At the time of the purchase it was being used as a small apartment dwelling and could be readily adapted for use. This fact had a definite bearing on its re-sale value. While the house is large, it is situated on a small city lot in close proximity to similar houses on either side. The other houses on the street are substantially constructed and give evidence of the interest of their owners in their upkeep and care. There is a public park across the street which it was thought could serve as play space. Schools for all ages, churches, child guidance clinic, stores and the Winnipeg General Hospital are nearby. A public transportation bus line runs at the end of the street.

The living accommodation was intended for a maximum of ten girls and house staff. The main floor contains a large living-room, dining-room and kitchen. A smaller room
off the entrance hall is used as an auxiliary office. In the basement is a large playroom for more strenuous indoor play. This room is equipped with a piano, record player, radio, sturdy chairs and couch, a portable ping-pong table and other games. The room is in constant use by the girls in groups or with their individual friends.

The second floor contains one large bedroom to accommodate three girls, one single bedroom, a bedroom for two girls and a bedroom for the housemother. The third floor opens into a large study or play space. Off this are three bedrooms - two accommodate two girls each and the third bedroom is for the cook. There are bathroom facilities on the second and third floors and in the basement.

Each girl has her own furniture and closet space and is encouraged to have her own possessions around her. Furnishings are not elaborate but the use of colour and arrangement creates a comfortable "homey" setting. The kitchen is perhaps one of the most popular rooms in the house. It is spacious, bright and a favourite rendezvous for groups of one, two or more girls with the housemother and the cook.

The Home lends itself to living as a family unit. The house staff and the girls eat together in the dining-room. The girls are very proud of their 'home' and take considerable pleasure in showing it to their friends.

Administrative, casework and clerical staff are located in a suite of offices situated about five blocks from the residence.
Personnel: The Executive Director and caseworker were the only two professional people directly employed by this agency in the initial stages. The Director is a trained social worker with many years of experience in the area of social casework and in the administration of social agencies - both in the field of child welfare. The caseworker had one year's formal training in a school of social work and ten years' experience as a caseworker in the field of family and child welfare.

The Director has the overall responsibility for the functioning of the agency in co-operation with the Board of Directors. The caseworker is responsible for all matters pertaining to casework service. This covers intake and discharge planning; direct casework services to the children in care; contacts with the child guidance clinic as to screening, psychiatric consultation and other related services; community contacts affecting work with the children such as schools, churches, group leaders, etc; interpretive and follow-up work to the referring agencies and contacts with the housemother regarding casework matters.

While each had their own area of responsibility, it was found that in practice they shared responsibility as to the integration of agency policy. The Director was also in a very real sense co-caseworker. Because of the very close working relationship between Director and caseworker and the relationship of each to the children and staff in the living
situation, it was possible for the Director and caseworker on a consultative basis with each other, to establish integrated casework planning for the individual child.

Referring again to the study of 1946, Dr. Mayer in his report sets out the qualifications of an Executive for a child care institution as follows, -

".......... such a person must have some experience and training in child care besides sufficient administrative ability to keep the wheels running smoothly. He must have the ability to work with modern concepts of child care, to understand the language of social workers, psychologists, psychiatrists, as well as the language of house mothers, maids, cooks and any man. Most of all, however, he must understand the language of the children themselves and must be able to give them the feeling of acceptance and warmth. He must be aware of changing concepts in child care work and be able to select and adopt those which will be of greatest value to the particular children under his charge." (1)

Having had several years of satisfying and productive practice in the field of social work, primarily in relation to child welfare, this Director brought to a pioneer project such as the Children's Home, a rich experience. In addition to her administrative ability she has an exceptional understanding of and feeling for children of all ages. Because of her status as a social worker she was also able to make an outstanding contribution to the field of child welfare in Winnipeg.

The goal of the agency was to employ house parents but in the initial period, suitable persons were not available. The initial residential staff consisted of two regular house mothers and one relief house mother. There was a regular cook

and a relief cook, a part-time janitor and a cleaning woman who came in weekly. One house mother and the cook lived in the Centre.

There is adequate relief for each member of house staff. The practice is to rotate off duty periods, each house mother having two consecutive days off weekly where this is possible. Each day there are free periods when the children are at school when the house mother can relax. The cook is free each evening after supper and in addition has one full day off during the week. On Sundays, the cook is free after mid-day dinner. Sunday evening suppers are simple and this period of the week is a much cherished time for the girls. They take turns in preparing supper and within limits they can exercise some choice as to what the menu will be. These Sunday suppers provide an excellent opportunity for mutual relationships.

In the initial stages of the programme, psychiatric, psychological, educational and recreational services are supplied by using resources within the community.

The psychiatrist is the director of the Local Child Guidance Clinic. He does not have special training in child psychiatry nor is he an analyst. His function is to interview each child prior to admission, preside over the general conference which establishes diagnosis and a tentative plan of treatment. Because he is familiar with the programme being built up at the Children's Home, he is able to materially assist in interpretation to each child. Regular
consultation periods of one hour per week are used. In actual practice this psychiatrist is most generous in giving extra time when this is required and he is gradually being drawn in more and more in an advisory capacity as the programme develops. The programme which he directs for the local School Board is largely geared to psychiatric problems arising in the city schools involving interpretation to school principals and teachers as well as making referrals to suitable social agencies in the community. This is also a developing programme within child welfare. There are social caseworkers on the staff to whom are assigned consultative services to individual schools. This policy has been extended to allow the caseworker from the Children's Home to have direct access to the schools attended by children in treatment. Extension and integration of the services of this Clinic will mean its increased usefulness to the Children's Home.

Psychological testing as well as other clinical services such as remedial reading, special tutoring and special school placements are provided by the Child Guidance Clinic. This is of particular advantage in the matter of difficult school problems.

The appointment of a social group worker to the staff has been under consideration for some time and as the service grows will be a necessity. In the meantime, local social group workers are being used where the need is indicated with the caseworker from the Centre acting as liason.
A local physician and surgeon acts as the medical consultant in this programme. He contributes his services to the project because of his personal interest in it. On occasions he calls at the Centre in case of illness. Generally speaking the children are taken to his office for examination, consultation and referral. Any extensive medical or surgical care needed is provided through the local hospitals and medical clinics.

To date, volunteers have not been used extensively in this programme. For a brief period a young student teacher was used to teach handicrafts to those who wished to participate. Because of her interest in sports and outdoor activities she was also active in planning hikes, skating parties and swimming. She became acquainted with the project through her interest in one of the girls at the Centre who had been known to her previously. Later, a young woman currently attending the local University and contemplating a career in social work, served in the capacity of co-ordinator of group activities. Both volunteers were under the supervision of the caseworker.

**Diagnostic Study and Intake Procedure:** Referrals are accepted from all recognized social agencies who give continuing service to the child's family. This is necessary whether the agency is the child's guardian or not. This requirement is regarded as an integral part of the treatment programme for each child.
As referred to earlier, all children eligible for admission are screened through the Child Guidance Clinic. A complete social history is submitted to the Clinic and the Centre, by the referring agency. Preliminary discussion with the referring agency is usual when professional staff get together to explore alternative resources for the child.

The psychiatrist and clinical personnel have seen the child and all aspects of the child's problems are known to the screening conference. This conference is attended by the psychiatrist, psychologist and other clinical staff - teacher of remedial education, and casework staff from the Centre and the referring agency. If the services of another institution seem probable, the casework staff of that institution is asked to attend the conference. Should an application be made direct to the Centre, it is channeled back through a family service agency so that every means of help has been given to keep the child a member of her own natural group. The matter of grouping at the Children's Home is of primary importance and is carefully considered when a new admission is discussed.

To be eligible for admission the child should be of average intelligence, in good physical health, not delinquent, able to live in an unlocked institution and participate to the extent of her ability in community recreational and school life. Intake policies are kept flexible and children who present psychosomatic symptoms are considered. While normal intelligence is stressed, it is recognized
that this can be affected by emotional factors.

The placement process is kept as flexible as possible and is child-centred. The caseworker from the referring agency is expected to take care of the preliminary preparation of the child for placement. The reason for placement is fully discussed with the child. Information as to the programme of treatment at the Centre is given. The child is given an opportunity to thoroughly evaluate this placement in her own way and she makes her own decision as to whether she can participate in the programme.

The child's caseworker and the caseworker from the Centre, work very closely together on the mechanics of placement. The child is brought to the caseworker's office at the Centre where the more intimate details of the setting are described and where the child can ask any questions which concern her. Usually at this time an appointment is made for the child to return to see the Centre and meet the house staff. A further visit is arranged for the child to spend some time with the group in residence, usually to have supper and spend the evening with the group. The group in residence as well as house staff are prepared for the newcomer, prior to her visits. Placement usually follows quickly after the final visit, but the child is never hurried into a decision. This preparation for placement takes from two weeks to one month depending on the child.

On admission, the institutional caseworker assumes casework services to the child, but if a more gradual transfer
is beneficial, this is worked out between the caseworker's concerned.

The referring agency continues casework services to the child's family and this is closely integrated with services to the child.

**Treatment:** The treatment programme offered at the Children's Home of Winnipeg is an integration of the total living experience of each child, with an individualized casework plan supplemented by psychiatric consultation. This, of course, applies to the child's education, recreational activities, care of her health, contacts with family and community and planning for her return to the community.

Great care is exercised in evaluating the needs of each child at the point of admission and every effort is made to individualize the programme. An unusual opportunity for the intensive concentration of casework skill and the constructive use of staff and community resources is possible in a small, controlled residential setting such as this. Through a process of constant re-evaluation it is possible to change the programme to meet each child's changing needs.

The approach to treatment, while geared to casework planning, is not the sole responsibility of the caseworker. The caseworker performs her particular function but does so as part of a team. In the immediate living situation which constitutes the treatment setting, the team is composed of, the Director; the caseworker; the psychiatrist and the staff of the Child Guidance Clinic; the house mothers and indeed,
the whole house staff. The team approach, however, does include all the people and activities touching the lives of these children under treatment - the school principal, school teachers, church and group leaders, arts and crafts teachers, the employment office personnel. Those engaged in the treatment of disturbed children cannot fail to use any and all positive factors within themselves and outside in the wider community as a helping medium.

When a child is admitted to the Children's Home, there is a period of approximately two weeks during which she has an opportunity to become acclimatized. Except for registration at school and casual day-to-day contacts, there is no attempt made to form a casework relationship with her during this period. It is felt that each girl needs this period in which to become used to her new surroundings. It is also part of the therapeutic plan for her. During this period she has an opportunity to be directly under the care of the house mother who helps her to get established. The house mother is the person in immediate authority and upon whom falls the responsibility for training and disciplining in the day's routine, for the household management and the morale of the home. No pressure is exerted to have the girls form parental ties with anyone on the staff unless she so desires.

Limits of behaviour have to be set for the security of the individual girl as well as for the group, but within these limits each girl is free to act out her feelings in whatever way is most satisfying to her.
Rules and regulations are at a minimum within the Centre. Because of group living, rising time, school, mealtimes and bedtime is definite and each girl must take responsibility for being on time. The girls are encouraged, within the home, to take an interest in their personal appearance and to form good habits of cleanliness and tidiness. Duties around the house are not strenuous. Each girl is required to make her bed each day and keep her room tidy. She has an opportunity to share in other household duties such as setting the table, doing the dishes, dusting and helping with the baking. While each girl is expected to perform certain tasks, no pressure is brought to bear if she is too disturbed. Personal pride in their surroundings often results in considerable activity around the Home. One such incident will serve to illustrate. It was spring-cleaning time and the group decided they were going to help. Before very long they had organized a team to wash and polish windows and clean woodwork. The results were very gratifying to girls and staff alike. The atmosphere of a normal home life is preserved as much as possible. This includes observance of birthdays and other special days, and the girls are free to entertain personal friends, both girls and boys.

Participation as a staff member in Christmas festivities is a memorable event. One particular Christmas stands out as a demonstration of what can be accomplished in creating a group feeling among these disturbed children.

For days ahead, the Centre was a hive of activity.
The main floor was tastefully decorated by the girls, with evergreens and bright ornaments. A large tree was dressed and lighted in the living-room. Even mistletoe was hung in strategic places. Celebrations started Christmas Eve with a concert at the local church. The girls returned later to the Centre where the house mother had set out attractive refreshments in the living-room around the tree. Every one joined in carol singing until it was bed-time. Despite the fact that they were all adolescents, stockings were hung — and filled by the house mother. All were up at daylight on Christmas Day and entered whole-heartedly into preparing a special breakfast and helping the house mother stuff the turkey and prepare other eatables for the Christmas dinner. As the group sat around the breakfast table, the Empire Christmas radio broadcast was heard, culminating in the Queen's address. As the group participated in the programme, singing familiar songs and hymns with children around the world, the feeling of all staff present was that a relaxed home environment is a very potent weapon in helping these disturbed children. The Christmas dinner table was a masterpiece with table decorations made by the girls. The exchange of gifts at this time and the preparation that went into these gifts, had its own treatment value.

The educational needs of these girls is met through the use of local schools and outstanding co-operation has been offered by the staff of each school attended, especially where a child is a school problem. The caseworker prepares the
the school for each girl individually and contact is maintained with the schools while the child is in treatment.

The girls are free to attend the church of their faith and are encouraged to do so and participate in church activities.

Organized recreational activities in the community are used. The main resources in this connection are groups at the Y.W.C.A., where trained group workers are available, and Girl Guide and C.G.I.T. groups at the local church. The girls are encouraged to belong to a community group but have a choice as to whether or not they attend. The choice of a group is not made haphazardly but is integrated into the whole treatment plan. Until such time as a group worker is added to the staff, the caseworker is the liaison person with the group leaders.

Several girls belong to the church choir and the acceptance accorded them there has had considerable therapeutic value.

Clothing, pocket money, interests and hobbies have a definite place as tools used in individual treatment. Where music lessons, dancing lessons or other accomplishments can be used in casework treatment plan, these resources are made available. The programme of outside activities is such that seldom are all the girls home at any one time.

As already mentioned, weekly consultation with the psychiatrist is available. He knows each girl at the time of admission and sees her from time to time throughout the treat-
ment period when the need arises. Other members of the clinical team are active from time to time such as the teacher of remedial reading, special tutoring, or the psychologist in special instances.

This outside programme enables the girls to remain a part of the community while under treatment, and allows an easier transition back to their own homes or a foster home. Many of their community contacts are arranged with the idea in mind that the girls could continue them after leaving the Centre.

Casual employment on Saturdays or during the summer holidays is possible for those girls interested and able to avail themselves of this. Through this, training is possible in the use of money.

Extensive residential treatment planning is of little use unless work with the child's parents or foster parents is continued at the same time.

The girls all have some contact with members of their own family, controlled and arranged by the referring agency working with the caseworker from the Centre. This makes possible a more realistic approach to the mixed feelings these girls have toward parents and other adults - feelings with which they must be helped in order to be more secure individuals. Work with the girls in the Centre is interlocked with work being done by the referring agency with parents or foster parents. This agency will be continuing to work with the girl and her family when she returns to the community.
The length of stay in the Centre is dependent on the nature of the disturbance and the girl's response to treatment. In the first three years of operation, fifteen girls from eleven to fifteen years of age were admitted. During this period, two of these girls were in treatment for two and a half years. The average length of stay is fifteen months.

When it is possible, parents are included in plans for the child's treatment. This, of course, varies from case to case and where children are the wards of the referring agency depends on the agency's experience with these parents. When children come directly from their own homes or from temporary foster homes, work with parents is a very vital part of treatment. To date, no plan has been worked out whereby temporary guardianship can be assumed by the Centre where parents interfere or are unco-operative in treatment plans for the child.
Chapter IV

The Winnipeg Children's Home: An Interim Evaluation (1958)

The foregoing chapters have given a glimpse of the evolution of institutions for the care of children; and directed a closer look at the Winnipeg Children's Home in particular. As a basis of comparison, a descriptive study of twelve residential treatment centres in the United States has been used. Of the twelve centres described in this study, five were selected for closer scrutiny because in each, the programme was administered by a social worker. Their main function is to serve the emotionally disturbed child. While the remaining seven centres also serve the child, there is an additional function, that of providing teaching facilities for related professions; psychiatry, psychology and medicine. The latter are administered by physicians and have a major training and research responsibility.

It is proposed to evaluate the experimental programme at the Winnipeg Children's Home using the headings established in Chapter I. These are as follows: (1) The Groups Served, (2) Housing, (3) Personnel, (4) Diagnostic Study and Intake Procedure and (5) Treatment Programme.

1. The Groups Served:

It is only within recent years that the Children's Home of Winnipeg has assumed the status of a social agency in the accepted sense of the term. For approximately sixty years it was one of the larger custodial institutions in
Winnipeg, serving large numbers of children of all ages of Protestant parentage. In this connection the Winnipeg Children's Home closely resembles the five centres outlined in Chapter II.

The specific recommendations made by the study of 1946, which study is briefly outlined in Chapter III, were, "that a series of small living units located in middle-class residential areas be developed, close to school and community resources. That these units house boys and girls who should attend local schools and participate in local community recreational facilities. They should accommodate up to fifteen children normally and not exceed a maximum of twenty-one children." (1)

From the study of residential treatment centres covered in Chapter II, it is clear that there is considerable variety in the existing centres. Some include boys and girls, some one sex only; age range differ and the type of child served varies. The five centres chosen for closer analysis, care for both boys and girls although the age range varies as shown in Appendix I. Which age group in Winnipeg was to be served in this new type of institution? This and many other questions would have to be answered before a residential treatment centre could be commenced.

It is always easier to say what ought to be done for

children than it is to point out just how such programmes may become a reality. From the material already presented in Chapter III, it will be realized that the establishment of a treatment unit in this community to serve a small group of children would have to be approached with careful thought and preparation. This was especially true when this new service was being undertaken by the Board of an institution which traditionally had cared for large numbers of children, chiefly on a custodial basis. This type of child-caring institution was new to this particular community and if it was to be successful would have to be endorsed by the community.

While members of the Board of the Children's Home had carefully studied residential treatment centres in other communities in order to plan wisely, it was realized that none of these programmes could entirely apply to the Winnipeg scene. Limitations of community resources in connection with psychiatric consultation and social work staff necessary to the operation of such a centre had to be looked at realistically. The question of the cost of a specialized programme such as this had to be considered.

It has been mentioned in Chapter III that the large congregate institution which had belonged to the Children's Home had been sold. The amount realized from the sale had been placed in a building fund to be used when a project was decided on. In addition the Board of the Winnipeg Children's Home held in trust for the children of Winnipeg, substantial capital funds accumulated through the years from endowments
and various bequests. Through sixty years of service, the Children's Home was frequently the beneficiary of wealthy citizens and many others who were interested in the care of children. While the Board of the Children's Home was willing to be instrumental in initiating and operating this new programme, would the community be able and ready to carry the operating costs, if capital funds were depleted in the initial stages?

The 1952 study referred to in Chapter III indicates that the costs of treatment of emotional disturbance are of necessity high. It was valid, therefore, that this aspect of the project should receive careful consideration in the planning stages. Financing would also be a real factor in interpreting the programme to the supporting community. It is interesting to note from the study covered in Chapter II that seven of the centres reported on, received their major financing from community chests, federations and endowed funds.

The financing of this project is introduced here because of its importance in relation to the age group selected at the beginning. It is felt that the factors involved demonstrate tremendous growth on the part of the Board of Directors. They were willing to use their financial resources to start with the greatest need apparent in the community at the time but had vision enough to recognize that this programme should be community sponsored. They recognized also the interpretive value of admitting this particular age group despite the fact that criteria for treatability was not
always present in each child.

The most pressing community need for residential treatment in Winnipeg was within the adolescent age group of girls. It was decided to open one unit to care for this group and if its success was demonstrated then a decision could be made regarding the opening of further units. The age grouping was tentatively set to cover girls thirteen to sixteen years of age. This agency having previously served Protestant children, it was initially decided to restrict admission to children of the Protestant faith. Early in the life of this project the Board of the Children's Home recognized that the programme being offered should not be restricted and the admission policy was widened in scope to include all children regardless of religion, race or creed. This was a definite step forward.

It is noted from Chapter II, that four of the five centres studied are of Jewish faith and initially served children of the Jewish community. Policies are gradually becoming more flexible and non-Jewish children are being admitted on the basis of their treatability.

The age range at time of admission as shown in Table II (a) for the five centres outlined was from two years to eighteen years and over and three of the five centres admitted children six years and under. In all five centres the greatest concentration of age grouping was in the adolescent age. Table II (a), however, with the exception perhaps of Centre "C" shows a trend towards lowering the age
range at time of admission. All five centres, as outlined in Appendix I, served children of both sexes.

It should be noted here, by way of comparison, that early in the life of the Winnipeg project there were indications that in terms of age, children being admitted were in the lower age group. The Winnipeg community was also indicating a need for residential treatment facilities for boys as well as girls which might be absorbed by the Children's Home. This will necessitate an expansion of housing facilities as well as decisions regarding segregation of sex and age group.

Housing:

The five centres studied in Chapter II evolved from larger institutions and utilized the buildings they inherited in which to establish their treatment programmes. While the new project of the Children's Home of Winnipeg evolved from a large congregate institution, it was not necessary to utilize old buildings, for the following reason.

Referring to the historical background of the Children's Home in Chapter III, it will be remembered that the large institution had been sold. The Receiving Home which had been operated by the Board for the Children's Aid Society was acquired by that Society and operated as a part of their service. The monies realized from this property had been designated for a future building when a project was decided on. It was considered wise at this juncture not to undertake the erection of a special building in view of the experimental
nature of the project. The wisdom of this decision was soon demonstrated.

A description of the housing facilities purchased by the Board of the Children's Home of Winnipeg is given in Chapter III. Needless to say, much conscientious thought and effort had gone into the purchase of this property. It remained, however, for the test of using it to point up the lacks within it. Two of these showed up almost from the beginning (1) No space was provided within the residence for administrative offices and (2) The accommodation for houseparents was not adequate. From an administrative point of view many small difficulties could have been ironed out if the administration could have been on the spot at the time of difficulty. Similarly, the caseworker felt that she should have been more accessible to both house staff and children. Even an apparently simple thing such as this often raised problems particularly with lay house staff who cannot possibly know what is involved in a social agency office and can chafe a bit when they have to wait for action. As far as the caseworker was concerned, this was overcome in part by utilizing what had formerly been a small reception room near the front door and converting it into an office. This room served a double purpose as the housemother kept her petty cash, household accounts, etc. there. The caseworker used this office after the children's school hours and the children quickly came to recognize this as a place apart for their use when they needed help. The children passed the agency offices on
their way to and from school and appointments for them could readily be arranged there. With disturbed children, however, their needs cannot always be met on an appointment basis.

In comparing the physical set-up of the Children's Home of Winnipeg with the general accommodation available in the five centres outlined in Chapter II, there is, of course, a variety of arrangements depending on the building or buildings being used. An important feature which is common to all is the adequate provision made for accommodation for house-parents. This accommodation ranges from a self-contained apartment to two or three rooms and bath provided apart from the children. Sleeping arrangements for the children vary. In some centres there is a combination of single bedrooms and rooms with space for three, four or five children. In one centre, dormitories are used. Provision is also made for administrative, clerical and professional staff, if not within the centre itself, then in close proximity to the centre.

Because the grouping of children in this type of institution is of paramount importance, one of the criticisms of the physical facilities of the Winnipeg Centre, would be lack of single bedrooms. This constituted a real problem when a new girl was being added to the group and when it became necessary to regroup sleeping accommodations for those already in residence. Ideally, it is preferable to have individual rooms. While it was possible for two or more children to share a room, the questions which arose around what children would room with each other, was time consuming. A greater
number of single sleeping rooms helps further individualization of treatment, more careful grouping and a more flexible living condition.

While the location of the centre is ideal as far as proximity to community resources is concerned, the lack of adequate play space around the building was a problem. The park across the street, referred to in Chapter III, while useful for a group under supervision, was at times more a hazard than a help. Since this park was open to the public it was difficult at times to offer as adequate controls as would have been desirable.

The location and appearance of the centre was an asset in effectual interpretation to the community. Recognizing that children living away from home already feel different from other children, it was important to avoid the many unnecessary appurtenances of institutional life which would remind these children of their singularity. The children needed a home that looked like any other home in the particular residential area. Through this it is felt that the immediate neighborhood came to realize that the needs of these children were similar in many respects to those of their own children. With this knowledge they were better able to understand the programme that was being set up.

**Personnel:**

Because residential treatment is such a new tool in the care of children, it is still in the experimental stages. Evidence shows that this is true even in those areas where
experimentation has been going on for several years. Each community varies in its approach to this new service determined largely by the community resources available. There is the danger that those involved in setting up such a programme may, in their enthusiasm, tend to forget that progress in establishing this type of service can only be made as the community permits. This involves careful and constant interpretation that enlists the kind of community support that is based on a demonstration of the enduring value to the child and the community. In other words, to start where the community is and gradually expand.

It is pertinent at this point to recall the review of the local situation in Winnipeg as outlined in Chapter III. It was necessary to employ staff who could do the work of interpretation as well as the work of treatment. One of the outstanding weaknesses brought to light by the survey of 1942 was the inadequate standard of personnel and the almost total lack of trained leadership and staff.

Subsequent to this survey, social agencies in Greater Winnipeg had gradually increased the number and quality of their casework staff and through this had demonstrated an improved service to the community. It would have been unrealistic and impractical to introduce a programme at this point which did not have as its main focus the practice of casework.

The Chairman of the Winnipeg Council of Social Agencies, in acknowledging the Report of the Study of 1946
also referred to in Chapter III, conveyed the feelings of those who would be instrumental in planning when he said:

"The Council wishes to state that Dr. Mayer's visit to Winnipeg and his report have in the main given emphasis and greater strength to beliefs and convictions that many of our local child care workers have held for some time .......... The Council believes that our institutions and child placing staffs can and will change their programmes and buildings to meet this need. The child care programme in Winnipeg has now entered a transition period.......... In some ways Dr. Mayer's recommendations are counsels of perfection.......... distant ideals which we hope to achieve eventually." (1)

The task of the Children's Home was actually not to make over an old institution but to set up a new social agency in which this new residential treatment programme might grow and expand.

Keeping in view this goal, the professional staff who undertook to start the programme hoped to lay the foundation for a sound administrative structure and endeavour to demonstrate what intensive casework could do to help disturbed children. In the initial pioneering of this project the need for academic standing for professional staff was recognized and those who undertook the "spade work" emphasized that when this aspect of the project was accomplished, they would like to see other qualified personnel take over. Continual self-evaluation is absolutely necessary in such a project as this, and continuing progressive standards point

to higher academic standards for all professional staff. Comment should be made here that the community was not ready for a high salaried, qualified person at first but experience over the first five years of the project indicated that progress was being made in this area. The greatest number of casework staff in the five centres outlined in Chapter II have a Master's Degree in social work. It is recognized that this is desirable. However, experience in this type of programme has demonstrated that academic standing is not enough. The professionally trained social worker who works in an institutional setting, particularly a residential treatment centre, also needs to have the personal attributes to fit her as a member of a team made up of lay people as well as those professionally trained. Also, in the gradual formation of this new social service there were dark days when the right kind of house parents were unavailable in the community. In order to preserve the life of this project it was necessary for the Director and caseworker to share the function of housemother.

The results of switching roles were both positive and negative in character, positive in that such a close contact with each girl, if viewed from a casework point of view, contributed immensely to understanding the individual girl and her problems, but negative in that it distorted the kind of relationship that we usually consider should exist between caseworker and client. Assuming the role of housemother meant entering the area of discipline. This often led to confusion in the minds of the girls as to relationship and necessitated
constant interpretation within the group in order to preserve the role of each staff member. The administrative and interpretive work of the Director was also temporarily delayed by this change of role.

The question of frequent turnover in house staff is recorded by the centres studied in Chapter II. In one particular instance the social group worker substituted until a suitable house mother could be found. While this was not the function of the group worker, it was found that the temporary substitution was helpful in promoting good staff relations and provided a more realistic basis for the children to form a relationship with her. While a similar substitution in the Children's Home did not benefit the casework relationship, it did provide an excellent opportunity for both Director and caseworker to find out firsthand what is involved in being a house mother. While the importance of the role of house parents was always recognized, this experience provided additional interpretive material for both the Board of Directors and the larger community.

Further, in discussion of professional casework staff, the question of time spent with each individual child is worthy of note. While the staffs and number of children served by the five centres outlined in Chapter II cannot be adequately compared with a small unit like the Winnipeg Children's Home, it is noted that the caseworker in most instances sees each child once a week. Indications in this
study are that more frequently than once a week would be desirable. Viewing this in relation to the Winnipeg Children's Home it is suggested that some thought be given to increasing the casework staff. The first three years of this project also indicated the desirability of adding a qualified social group worker to work in conjunction with the caseworker.

As mentioned in Chapter II, the house parents are the focal people in residential treatment. This was clearly demonstrated in this project where the individual approach to the behaviour of children was a new concept. Every possible resource in this community was tried for suitable persons to assume the role of house mother and the best available were employed. Some had had experience in other institutions connected with children. Educationally and culturally they were carefully oriented to their function in the treatment process. On the whole those employed initially made an acceptable contribution but seemed unable to sustain this. In some instances they had never really accepted the treatment programme. Aggressive acting out behaviour is not easy for the average lay person to accept and live with daily. Similarly it is not always understood that the conforming child can be as emotionally disturbed as the child who has temper tantrums.

In the case of those house mothers who lived outside the Centre, it was felt that their home responsibilities interfered to some extent with the contribution they could make.

The turn-over in house staff was the greatest single problem in the initial stages of this new project. In the
Study covered in Chapter II it is noted that this is also a major problem.

In child-caring institutions in Winnipeg, the training of house staff has hitherto not received the attention which is needed. The in-service training of house staff in the Children's Home is a major part of the administrative planning. Through an Association of Child-caring Institutions set up as recommended by the Study of 1946, some realistic planning is being undertaken. This is being done with the co-operation of the local School of Social Work. Each year courses for institutional workers have been conducted under the leadership of a trained social worker. The need is great and this is at least an attempt to meet the need.

It is noted that in the Centres studied in Chapter II there is extensive planning for in-service training of all institutional personnel. This includes not only the orientation of all house staff but extends in some instances to the inclusion of house parents in case conferences where treatment plans are formulated. Regular conferences during the treatment period provide opportunities for those in direct contact with the children to give expression to the problems they encounter and to receive help with these problems.

In addition to the in-service training programme sponsored by the Association of Child-caring Institutions in Winnipeg, a continuous interpretive and training programme is carried on within the Children's Home. This is carried out through regular conferences with the housemother, director and caseworker, in connection with treatment
plans for each child. At the time of a new admission, the house mother is always well prepared ahead of the actual placement. She is aware of the presenting problem and the tentative treatment plan. It has not been possible, as yet, to include house mothers in a conference which the psychiatrist and clinical staff attend.

The focus of all interpretive and in-service training has been towards raising the status of house parents in the hope that the right type of person will be attracted to this important work. This is only one of the many problems to be met in an institutional community where, heretofore, house staff has not been required to be aware of the emotional factors in the behaviour of children. Referring to Chapter II it is noted that in the five centres outlined, with very few exceptions, the house staff employed have had high educational standards coupled with considerable experience in working with children. While high educational standards are desirable, the presence of a healthy personality is of equal importance.

What qualifications do we look for in the houseparents in relation to the services we expect in a residential treatment centre? The experimental period at the Winnipeg Children's Home demonstrated two extremes - one, the well organized, firm, adequate human being who sees that the house is clean, the children properly clothed, meals on time and who, though she may be a joy to the administration, somehow misses something of warmth and generosity toward children. At the other extreme is the somewhat messy, good-natured
person, who forgets this and that, but is obviously so good for the children that one wonders if the building is going to hold together. The ideal person is one who can strike a balance. Experience has demonstrated that in order to attract the right people to this important job, the administration will have to provide better salaries, adequate living accommodations to ensure privacy from the strains and drains of this job and generally improved personnel practices. Part of the sense of inferiority of institutional children is the projection of the sense of inferiority of the house staff as related to the better-educated, more socially secure individuals who support the programme.

It should be noted at this point that one of the main problems highlighted in the five centres studied in Chapter II was insufficient psychiatric time. This would seem to be a universal problem in residential treatment programmes despite the fact that the five centres covered are situated in or close to the source of this service. In a smaller community such as Winnipeg, psychiatric service is limited. However, if the new programme of the Winnipeg Children's Home is to grow and expand, it is recommended that some effort be made to increase the psychiatric time available. This would seem to be most pertinent in relation to diagnosis at the point of intake and increased consultation time throughout the course of treatment.

**Diagnostic Study and Intake Procedure:**

In common with the five centres outlined in Chapter II, the Winnipeg Children's Home accepts referrals from public
and private social agencies, assuming that all other resources to help the child have been explored when referral is made. Also, the Winnipeg Children's Home is in accord with the basic concept that it is important to keep a child with his family where possible and referral through a social agency helps to safeguard against unnecessary separations. Should an application be made direct to the Children's Home, it is channelled back through a family service agency so that every possible means of help has been given to keep the child a member of her own natural group. This aspect of the admission programme is common to the five centres studied in Chapter II and it is felt helps to ensure the proper use of the residential treatment.

In the early experimental stages at the Winnipeg Children's Home it was necessary to be critical of some of the referrals made by agencies. This was primarily due to the fact that in many instances the term "emotionally disturbed" did not apply to the child being referred. The tendency was to use the newly created agency for children who were having problems in foster homes or their own homes but who were not necessarily emotionally disturbed. Through interpretive inter-agency conferences over a period of time it was pointed out that the Winnipeg Children's Home was no longer a custodial institution and could not be used as a dumping ground for children whose problems could be dealt with elsewhere. This sitting down together to discuss mutual problems had many beneficial effects. Not the least of these was that the best
qualified personnel should be employed in the area of family and child relationships.

The diagnostic conference, using the team approach, and preparation of each child for admission, as outlined in Chapter II is similar to that used at the Winnipeg Children’s Home. The question of grouping had to be carefully considered when a new admission was being discussed. This factor, which is emphasized throughout Chapter II was highlighted by an experience early in the life of this new project.

A girl was admitted who proved to be a child who required more control than an outside programme could provide and one who could not respond to intensive casework treatment until her behaviour was more controlled. In the short time she was at the Children’s Home, the whole nature of the group changed for the worse, and following her discharge to a custodial institution it took many weeks of work with the original group to regain the ground lost — ground lost not only with the girls but with house staff and the community as well, for they were unable to cope with or to understand the marked change in the group. Further admissions had to be delayed for a time.

It is difficult for a group of normal children to live reasonably happily together, but to combine a number of children with deep emotional disturbances, resulting in varied types of behaviour, is no small undertaking.

In building this group up it was necessary in the early stages to build slowly and carefully. In a small group
such as this it is almost impossible to plan in order of admission when two or more girls are being considered. With each girl admitted, the character of the group is altered and subsequent admissions must be carefully planned. This, of necessity, means that admissions cannot be accepted too frequently and must be intelligently spaced. This is particularly true of the first years of operation when there must be certain standards, attitudes and social climate built up. It is unwise and impractical to gather a group together for the sake of swelling numbers and keeping costs down. This could defeat the purpose for which the service was created. From the point of interpretation to the community this can be a difficult point to get across.

Some factual information from the first year of operation will serve to illustrate. During 1951, seven different girls were admitted and two discharged. In all, seventeen girls were discussed as possible admissions. Aside from the seven admitted, only five of the other ten were formally discussed following their examination at the Child Guidance Clinic. The needs of the other five were such that even before examination, they had progressed too far in a delinquent behaviour pattern to be able to accept the programme of treatment offered at the centre.

As with most of the centres outlined in Chapter II the Winnipeg Children's Home stipulates that children must be able to live in an unlocked institution and participate in community schools and recreational activitie.

While normal
intelligence is stressed, it is recognized that I.Q. can be affected by emotional factors and that potentially children thus affected could be within normal limits. It is proposed to digress at this point to give an illustration.

Mary, aged thirteen, was accepted into the Children's Home during the first year of its operation. The psychiatrist hesitated to say she was backward; rather did he feel that disturbances and poor behaviour might be the result of emotional blocking.

Mary came from a deprived home where an invalid mother was unable to give her adequate care and training. Her father had deserted the family. Mary appeared dull and showed tendencies to become delinquent. In working with this family situation a social agency had tried for two years to place Mary temporarily in a foster home. Because of the special care that she would need, the right foster home could not be found.

When Mary came to the Children's Home she was a pathetic looking child with stringy, unkempt hair, her face flat and unresponsive. She seldom smiled or showed any sort of emotion. She had little or no habit training, often ate with her hands, did not wash properly and took no pride in her appearance. She was backward at school and her chief companions were children several years younger.

Early in her stay at the Children's Home it was found that Mary's intelligence was limited and that intensive treatment was out of the question. Frequent evaluation with
the Child Guidance Clinic and school personnel, established this fact. It was decided to plan a short period of environmental treatment.

Mary's response to this was miraculous. She responded to the kindness and understanding of house staff and the group in residence. It was found that she worked well with her hands, and this ability was explored to its full extent, and she was given every opportunity to excel in this area. She acquired acceptable personal habits; developed a sense of humour and her expression became lively and interested. This, together with an interest in her clothes and appearance made her a well accepted member of the group. Nine months after admission Mary was able to fit into a carefully selected foster home.

It was possible to give this type of service when the group was smaller but as the group built up with girls of average intelligence or better, a decision has to be made as to whether a girl like Mary can be helped.

In the early days of this new project, a demonstration such as the above had interpretive value for the community. A placement in a custodial institution for backward children would perhaps have been a more costly alternative both in terms of Mary's happiness and to the taxpayers of the community.

Treatment Programme:

The treatment programme at the Winnipeg Children's Home has used individualization rather than regimentation as the keynote. The agency's total resources including all personnel, psychiatric, psychological, schools and
recreational facilities available in the community are geared to the needs of the individual child admitted. Actually, the treatment process is two-fold; a combination of casework interviews with utilization of all the child's day to day living experiences. All of this is undertaken from the beginning with a view towards the child returning to the community.

At this stage in the life of the new Children's Home project, comparison of scientific methods used is not feasible. However, using the five centres studied, as a guide, certain goals might be kept in mind. All of these centres use psychotherapeutic interviews conducted by qualified caseworkers in consultation with and in many instances directed by psychiatrists. This, of course, presupposes the availability of fully qualified personnel and increased use of psychiatric time. Winnipeg, as a community, has not arrived at the stage yet of being able to offer this standard of scientific treatment in a residential treatment centre, but it is a goal worth striving for.

It is also suggested that, as the project grows, there will be a need to add school facilities within the residence. This would provide facilities for those children who are treatable but because of the nature of their disturbances are unable to withstand the competition of a public school. From the point of view of interpretation of the programme, the community schools have been a valuable resource. One school principal verbalized his conviction when he said,
"I see these children when they come to my school and I see them when they are discharged from care. I know they are being helped by individual treatment."

In the five centres studied, the participation by parents in treatment plans varies, but the general trend would seem to be the best chance for successful treatment of a child exists where the agency is able to work closely with the parents as well as the child. At the Children's Home of Winnipeg, this aspect of the treatment programme needs to be examined more closely. True, the referring agency continues to work with parents or foster parents towards the child's return but it is suggested that more direct contact by the treatment agency with the parents is desirable. Where new foster parents need to be found for a child, some thought might be given to including this as a function of the treatment agency. One of the difficulties encountered in these first years was delay in planning when the child was ready for discharge from the centre.

To establish criteria for successful treatment of emotional disturbance is difficult, for in many ways it is attempting to measure human happiness. It would seem safe to say, however, that treatment has been successful if, (1) a girl can return to her own home or to a foster home, and make a sufficiently good adjustment that she can both give and receive reasonable satisfaction in daily living; (2) if she is able to adjust to school life or employment and to accept responsibility in community living because she feels
more socially adequate, more assured of her inherent worth and strengths as an individual.

There have been such examples; likewise there remain many difficult cases in which nothing like success can be claimed. There is still much to do. But it is fair to say that "the most irresistible of all causes" is being tackled with more insight, skill and better facilities than twenty or even ten years ago.
### APPENDIX A: Information on Comparative Centres Studied

#### Table 1. Size and Location

<table>
<thead>
<tr>
<th>Centre</th>
<th>Location</th>
<th>Capacity (Number of children)</th>
<th>Age of Children served-(a) (years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>In a large city. Serves a very large region</td>
<td>109</td>
<td>5 - 16</td>
</tr>
<tr>
<td>B</td>
<td>Situated close to a large metropolitan area and a part of a child-caring agency.</td>
<td>24</td>
<td>6 - 12</td>
</tr>
<tr>
<td>C</td>
<td>Situated close to a large metropolitan area.</td>
<td>200</td>
<td>6 - 16</td>
</tr>
<tr>
<td>D</td>
<td>In a large metropolitan area and part of child-caring agency.</td>
<td>45</td>
<td>2 - 21</td>
</tr>
<tr>
<td>E</td>
<td>In a large city. A private agency.</td>
<td>20</td>
<td>2 - 18</td>
</tr>
</tbody>
</table>

(a) All institutions served both sexes.
Table II(a) Age at Admission of Children in Residence as at time of Study

<table>
<thead>
<tr>
<th>Age in Years</th>
<th>&quot;A&quot;</th>
<th>&quot;B&quot;</th>
<th>&quot;C&quot;</th>
<th>&quot;D&quot;</th>
<th>&quot;E&quot;</th>
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</thead>
<tbody>
<tr>
<td>Under 5</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>5 - 6</td>
<td>6</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>6 - 7</td>
<td>5</td>
<td>3</td>
<td>1</td>
<td>-</td>
<td>3</td>
</tr>
<tr>
<td>7 - 8</td>
<td>7</td>
<td>1</td>
<td>-</td>
<td>3</td>
<td>-</td>
</tr>
<tr>
<td>8 - 9</td>
<td>6</td>
<td>2</td>
<td>4</td>
<td>-</td>
<td>4</td>
</tr>
<tr>
<td>9 - 10</td>
<td>10</td>
<td>2</td>
<td>5</td>
<td>3</td>
<td>4</td>
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<td>10 - 11</td>
<td>11</td>
<td>1</td>
<td>10</td>
<td>2</td>
<td>1</td>
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<tr>
<td>11 - 12</td>
<td>6</td>
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<td>13</td>
<td>5</td>
<td>1</td>
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<tr>
<td>12 - 13</td>
<td>6</td>
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<td>24</td>
<td>3</td>
<td>1</td>
</tr>
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<td>13 - 14</td>
<td>5</td>
<td>1</td>
<td>34</td>
<td>7</td>
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<td>15 - 16</td>
<td>5</td>
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<td>33</td>
<td>3</td>
<td>2</td>
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<td>16 - 17</td>
<td>2</td>
<td>-</td>
<td>20</td>
<td>-</td>
<td>1</td>
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<td>-</td>
</tr>
<tr>
<td>18 - and over</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Totals</td>
<td>81</td>
<td>11</td>
<td>198</td>
<td>40</td>
<td>20</td>
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Table II(b) Distribution of Children by Sex at time of Study

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Boys</td>
<td>51</td>
<td>7</td>
<td>129</td>
<td>27</td>
<td>12</td>
<td>226</td>
</tr>
<tr>
<td>Girls</td>
<td>30</td>
<td>4</td>
<td>69</td>
<td>13</td>
<td>8</td>
<td>124</td>
</tr>
<tr>
<td>Totals</td>
<td>81</td>
<td>11</td>
<td>198</td>
<td>40</td>
<td>20</td>
<td>350</td>
</tr>
</tbody>
</table>
Table III  Length of Stay of Children who left Treatment Centres during the two-year Period 1950-1951

<table>
<thead>
<tr>
<th>Length of Stay</th>
<th>&quot;A&quot;%</th>
<th>&quot;B&quot;%</th>
<th>&quot;C&quot;%</th>
<th>&quot;D&quot;%</th>
<th>&quot;E&quot;%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 1 month</td>
<td>1.5</td>
<td>9.7</td>
<td>1.7</td>
<td>7.1</td>
<td>6.4</td>
</tr>
<tr>
<td>1 to 3 months</td>
<td>3.0</td>
<td>6.5</td>
<td>5.2</td>
<td>-</td>
<td>8.5</td>
</tr>
<tr>
<td>3 &quot; 6 &quot;</td>
<td>10.6</td>
<td>3.2</td>
<td>5.2</td>
<td>28.6</td>
<td>12.8</td>
</tr>
<tr>
<td>6 &quot; 9 &quot;</td>
<td>4.5</td>
<td>3.2</td>
<td>8.6</td>
<td>-</td>
<td>10.6</td>
</tr>
<tr>
<td>9 &quot; 12 &quot;</td>
<td>3.0</td>
<td>2.2</td>
<td>3.4</td>
<td>28.6</td>
<td>19.1</td>
</tr>
<tr>
<td>12 &quot; 18 &quot;</td>
<td>9.1</td>
<td>16.1</td>
<td>10.3</td>
<td>28.6</td>
<td>23.1</td>
</tr>
<tr>
<td>18 mos. - 2 yrs.</td>
<td>13.7</td>
<td>12.9</td>
<td>15.5</td>
<td>7.1</td>
<td>14.9</td>
</tr>
<tr>
<td>2 to 3 yrs.</td>
<td>18.2</td>
<td>9.7</td>
<td>32.9</td>
<td>-</td>
<td>6.4</td>
</tr>
<tr>
<td>3 &quot; 4 &quot;</td>
<td>25.9</td>
<td>19.3</td>
<td>6.9</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>4 &quot; 5 &quot;</td>
<td>4.5</td>
<td>6.5</td>
<td>5.2</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>5 yrs. or more</td>
<td>6.0</td>
<td>9.7</td>
<td>6.1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Totals</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>
APPENDIX B: BIBLIOGRAPHY

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